

# VICTOR Instructor Manual

## Veteran-Informed Care Training on Responsivity

Training curriculum for court  
system staff with direct  
justice-involved veteran contact



An initiative of the National Institute of Corrections in partnership with the Center for Court Innovation

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# Course Description

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The Veteran-Informed Care Training on Responsivity (VICTOR) is a training curriculum designed for criminal justice practitioners to gain specialized knowledge and skills for working with veterans. Data consistently shows that court based interventions and programs are most effective when practitioners have specialized training. Accordingly, VICTOR is designed to help practitioners understand the unique needs of veterans and their underlying criminogenic risk factors. The VICTOR curriculum is an educational resource on responsivity issues related to working with justice-involved veterans.

There are approximately 23 million veterans living in the United States, representing over seven percent of the U.S. population. Many active-duty soldiers return home with chronic nightmares, flashbacks, and emotional hypersensitivity—and many veterans are diagnosed with PTSD upon return. Countless others suffer daily from the side effects of trauma, yet do not come to the attention of mental health or medical providers.

Due to the ongoing conflicts in Iraq and Afghanistan, the United States is facing an additional influx of veterans who return home only to face new battles with mental illness, substance abuse, intimate partner violence, homelessness, and despair. The over two million U.S. troops deployed to Afghanistan and Iraq display an incidence of psychological damage significantly higher than the incidence of physical injuries. Approximately one out of six veterans returning from the conflicts in Afghanistan and Iraq has a substance use disorder, and one in five has symptoms of a mental health disorder or cognitive impairment. By 2008, 20 percent of Iraq and Afghanistan veterans had been diagnosed with depression or PTSD, both afflictions that have been shown to increase the likelihood of substance abuse and violent behavior.

As in the general population, veterans experiencing mental health disorders or substance abuse problems frequently exhibit behavioral symptoms that place them at risk for justice system involvement. In 2008, research on hospitalized veterans found that alcohol and drug problems appeared to account for much of the risk of incarceration among this population and an estimated 60 percent of the 140,000 veterans in prison have a substance abuse problem. A study by the Department of Justice's Bureau of Justice Statistics in 2004 found that nearly one in ten inmates in U.S. jails had prior military service.

The criminal justice system and the professionals who work within it must be responsive to the needs of veterans who come through the nation's police stations, courthouses, and jails. Veterans treatment courts are one popular avenue for addressing the needs of veterans in the criminal justice system. However, there are other types of programs, skills, and approaches which can help courthouses and practitioners practice "veteran-informed care." The course will cover these programs, skills, and approaches so that practitioners can be more responsive to the needs of veterans in the criminal justice system.

The curriculum is divided into five substantive modules, covering the following topics:

1. **Military and Veteran Culture.** Module 1 provides information and insight into military and veteran culture. **Lesson 1: Military Culture** contains an overview of military structure, service roles, and major aspects of military culture. **Lesson 2: Veteran Culture** asks participants to consider the question, *who* is a veteran? Once participants have explored the criteria used to determine veteran status, they will learn how the challenges involved in the transition from the military back to civilian life leads some veterans to become justice-involved.
2. **Risk Assessment.** In **Lesson 1: Risk, Need, and Responsivity**, participants learn how evidence-based screening and assessment is used to differentiate offenders according to risk level and needs. Participants will be introduced to the risk-need-responsivity model of offender rehabilitation and deepen their understanding of this model through independent study, group discussions, and activities. In **Lesson 2: Risk Assessment for Veterans**, participants learn how risk assessment can be utilized specifically with the justice-involved veteran population.
3. **Mental Health and Substance Use.** Module 3 introduces the ways in which mental health and substance use disorders affects veterans, including the context in which they experience trauma, common symptoms of mental health disorders, and treatment approaches. **Lesson 1: Mental Health**, gives participants an overview of mental health issues prevalent in justice-involved veteran populations, and related treatment approaches. **Lesson 2: Substance Use**, informs participants about common substance use disorders amongst veterans, and discusses the relationship between substance use and mental health.
4. **Navigating Veterans' Resources.** Module 4 provides guidance on navigating the variety of important benefits and services available to veterans and to their families from the U.S. Department of Veterans Affairs and other agencies. **Lesson 1: Navigating the U.S. Department of Veterans Affairs** discusses the source of the most well-known veterans' benefits, the federal Department of Veterans Affairs. **Lesson 2: Other Veterans Resources** identifies and explains useful resources outside the federal VA, including state departments of veterans affairs, community-based organizations, and the so-called Big Six veteran service organizations.
5. **Responsivity and Justice-Involved Veterans.** In **Lesson 1: Case Management**, participants receive an overview of case management, including the functions and tasks of the case manager, and discover how case management can improve outcomes for justice-involved veterans. In **Lesson 2: Responsivity in the Criminal Justice System**, participants discuss several aspects of responsivity in the criminal justice system: veterans treatment courts, procedural justice, domestic violence issues, and corrections-based programming. Lesson 2 also introduces the sequential intercept model for justice-involved veterans and explains how this model can help practitioners identify opportunities for linkage to services, and prevent further involvement in the criminal justice system.

## Objectives of VICTOR

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After completing this training, participants will be able to:

- understand the difference between explicit vs. implicit military culture;
- understand how veteran and military culture may impact a veteran's experience and behavior in the courtroom setting;
- understand the basics of risk, need, and responsivity;
- demonstrate active listening skills;
- understand the landscape of services available for veterans; and
- understand how the confluence of mental health, substance use, and military experience may lead to interactions with the criminal justice system.

## Target Audience

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Target audiences include criminal justice practitioners who interact with veterans during their work. This may include judges, attorneys, case managers, corrections and law enforcement staff, clerks, and more. It may include practitioners who work on a veterans treatment court team, and those who work with the non-treatment court population.

## Course Length

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The VICTOR course is four days in length, with a total of 19 hours of instruction time (7 hours of instruction per day plus one hour for lunch). The time allotted for each module is listed at the beginning of each module (including one or more 10-minute breaks in the morning and afternoon).

## How to Use this Manual

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This manual is designed to guide instructors through the teaching process. It provides step-by-step instructions for course content delivery throughout the training. The Instructor Manual is designed to provide specific language to be used for every component/slide of the curriculum. Each instruction is indicated by an Instructor Icon, which are detailed below. Keep in mind:

- You should read through this Instructor Manual in advance of the training and review each day's material before delivery to familiarize yourself with the content.
- Although a script is provided, you should establish a comfortable approach consistent with your personal style, demonstrate flexibility, and be able to speak authoritatively about the subject matter.
- Inform participants that they should follow along with you in their Participant Manual, which has Module and Lesson Overviews, as well as activities and other useful information.
- You should not read the text on the slides verbatim; instead, stick to the script/instructions provided.
- At the beginning of each new module and lesson, there will be an introductory slide meant to serve

as a transition. Although no accompanying instruction is provided, you should explain to the participants that a new section is starting (most likely after a break). Additionally, after each Module, there is a quiz, which is accompanied by a slide and an answer key.

- During open discussion, ask participants to elaborate, or ask follow-up questions as appropriate.
- Although there are not always explicit instructions for doing so, make sure to take questions from the participants whenever they arise. If a participant asks a question that you don't know the answer to, tell them you will find out the answer and get back to them.
- Use your judgment for pacing the material, and feel free to add more or less breaks as appropriate.
- For activities requiring small group work, do your best to vary the group make up-every time.

## Class Preparation

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Two weeks prior to class:

One week prior to class:

- Create Participant PowerPoint Handouts (with three slides per page)
- Copy the Participant PowerPoint Handouts and Participant Manual
- Insert Instructor's Name and title on the PowerPoint slide for Day 1
- Research and identify nearby national cemetery locations to prepare for discussion of this topic in Module 4 (see page 165).

Two days prior to class:

- Gather required materials:

- |  |  |
|--|--|
| <input type="checkbox"/> Laptop                  | <input type="checkbox"/> Flipchart, markers, and masking |
| <input type="checkbox"/> LCD projector           | tape or white board and white                            |
| <input type="checkbox"/> Screen                  | board markers  |
| <input type="checkbox"/> Speaker/audio equipment | <input type="checkbox"/> Timer (e.g., on cell phone)     |
| <input type="checkbox"/> Easel                   |  |

- Ensure necessary equipment and videos are working properly

Day of class:

- Arrive at least 45 minutes early and set up the classroom for up to 30 individuals (tables that seat 3–6 participants)
- Set up equipment and flipchart

## Evaluation Techniques

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|--|--|
| <input type="checkbox"/> Participant feedback—verbal | <input type="checkbox"/> Participant feedback—written survey |
| <input type="checkbox"/> Pre-VICTOR self-assessment  |  |
| <input type="checkbox"/> End-of-Module Quizzes (5)   | <input type="checkbox"/> Post-VICTOR self-assessment         |

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## Instructor Icons

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The Instructor Manual enables you to scan each page quickly to see what you need to do and say. The following icons represent each type of activity or action:



**Instructor:** Indicates when the instructor will impart information to the participants



**Ask:** Indicates when the instructor will ask a question



**Instructor Note:** Contains general instructor notes about the topic



**Activity:** Indicates that the class will participate in an activity



**Discussion Group:** Indicates that the class will break into discussion groups



**Flipchart:** Indicates when the instructor or participants will take notes on flipchart paper to capture a discussion



**Answer Key:** Contains instructor answer key to participant activity/quiz



**Multimedia:** Indicates when to show a multimedia file



**Reference:** Indicates that additional resources are being referenced to support information shared during the training

# VICTOR

## DAY 1

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# Introduction to VICTOR

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**Time: 1 hour, 45 minutes**

## Overview

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The curriculum begins by welcoming participants and introducing the instructor. It is designed to help participants feel comfortable and get to know the others in the room. Establishing rapport and putting the participants at ease will invite more open communication and sharing throughout the training. This module also explains the rationale for the training and provides an overview of the agenda for the course.

## Goals for the Instructor

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- Welcome and introduce the training participants to the instructors and to each other
- Begin to develop rapport with the training participants
- Provide an opportunity for the participants to express their feelings about being part of the training
- Explain the rationale for the training and provide an overview of the material to be learned

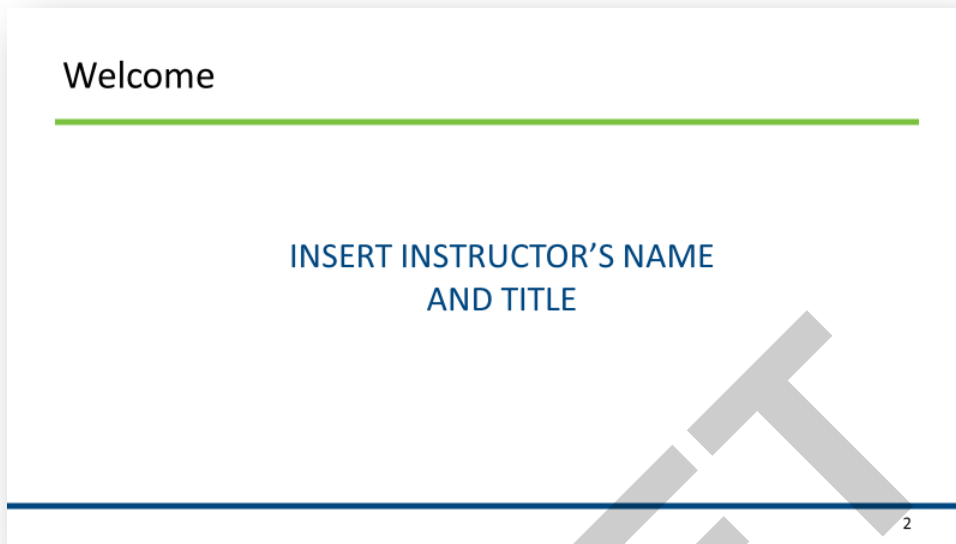
## Performance Objectives for Participants

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- Understand the purpose of the training and their expectations for the instructors, the training, and themselves
- Learn about the five substantive modules of the course and the objectives for each one
- Identify the goals participants have for themselves in their current positions

# Welcome

Time: 20 minutes



**Instructor Note:**

The purpose of this introduction is to set the stage for the next section of learning material and pique participants' interest. It is designed to be a fun and engaging way to introduce the topic and will often have participants wondering, "where is the instructor going with this?" or, "what does this have to do with what we're learning?"



**Instructor:**

Hello, and welcome to Veteran-Informed Care Training on Responsivity, VICTOR! My name is \_\_\_\_\_ and I will be your instructor for the next four days. We're going to be spending a lot of time together this week, so let's get to know each other. Rather than introducing myself using the traditional approach, I thought I'd give you the opportunity to use some of your best deductive reasoning skills to tell me what you think you know about me.



**Ask:**

Who wants to go first and take a guess at my background? Where am I from?

***Anticipated Response:***




Responses will vary.




**Ask:**

Now, what if I told you I was a veteran—what do you think you know about me now?

***Anticipated Response:***

	Responses will vary.
	<p><b>Instructor Note:</b></p> <p>Continue the activity by asking the group to guess details about various areas of your life, with an emphasis on military service. You might prompt them with questions such as the following:</p> <ul style="list-style-type: none"> <li>• What branch of the military did I serve in?</li> <li>• Have I seen combat?</li> <li>• How many times have I been deployed?</li> <li>• What was my job in the military?</li> <li>• What is my job now?</li> <li>• Was I injured in the military?</li> <li>• Am I married or single?</li> <li>• Do I have kids? If yes, how many?</li> <li>• Am I dog person or a cat person?</li> </ul> <p>Do not let the activity go on for longer than 5–10 minutes. Keep the discussion fun and lively. Try to include some questions that participants will likely guess incorrectly. Do not get too personal with your questions or answers.</p> <p><i>Variation:</i></p> <p>If many of the participants already know you, modify the questions to make them more challenging.</p>
	<p><b>Instructor:</b></p> <p>We all make assumptions. We make assumptions about other people, about situations, and about circumstances. For example, when I asked you to guess about my military background, you probably made some assumptions about me based upon your experiences, maybe what you observed before the session began, or what I look like. When we make assumptions, we use the data set from our past experiences to help us fill in missing information about a current situation. At times, making assumptions can be a very helpful approach to making sense of vast amounts of information we encounter every day. At other times, making assumptions causes us to misinterpret someone’s behavior or make judgments about people that affect how we interact with them.</p>
	<p><b>Ask:</b></p> <p>What are some assumptions you have made at work about some of the justice-involved individuals with whom you work?</p> <p><b>Anticipated Responses:</b></p> <p>“They’ll never change”; “This offender has a drug problem”; “This guy doesn’t respect the</p>

	judge because he’s sitting at the back of the courtroom and looking around too much”; “This guy doesn’t care about anything.”
	<p><b>Instructor:</b></p> <p>One problem with assumptions is that we tend to treat people based on our own beliefs about who they are and the lives they’ve lived. This does not account for the range of experiences that bring people into contact with the criminal justice system and their perceptions of the criminal justice setting. Once we challenge our assumptions and learn more about the people we are working with, we can gain a greater understanding of what brought them into the system and how we can better serve them. For example, people who have served in the military face a unique set of circumstances. As criminal justice practitioners, it is important for us to know how to identify and assess veterans, and to be fluent in the cultural aspects of being a veteran that may impact someone’s behavior and experience. Only then can we be responsive to the needs of veterans in our criminal system.</p>

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# Veterans in the Criminal Justice System

Time: 5 minutes

## Veterans in the Criminal Justice System

- 2012: **181,500 incarcerated veterans**
- 2001 – 2012, veterans from current wars in the Middle East accounted for 13% of veterans in prison and 25% of veterans in jail
- About half of all veterans in prison and jail had been told by a mental health professional they had a mental health disorder (more likely for combat veterans)
- Incarcerated veterans tend to be older and have a higher rate of divorce than non-veterans who are incarcerated

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### Instructor:

Over the next few days, we'll discuss military and veteran culture, as well as the physical, medical, and mental health effects of service and the difficulties that come with civilian reintegration. We will also discuss the role of governmental agencies that support and provide services to veterans.

According to a 2015 report from the U.S Department of Justice called *Veterans in Prison and Jail, 2011-12*, the number of incarcerated veterans has decreased from an estimated 206,500 (9% of the total incarcerated population) in 2004 to an estimated 181,500 (8% of the total incarcerated population) in 2011-12. This may be attributed to increased access to resources.

However positive a reduction in incarceration may be, the number of veterans incarcerated remains significant. Here are some highlights from the report: Veterans discharged during 2001-2012 (from Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn) account for 13% of veterans in prison and 25% of veterans in jail.

About half of all veterans in prison (48%) and jail (55%) had been told by a mental health professional they had a mental health disorder. And, incarcerated veterans who saw combat (60% in prison and 67% in jail) were more likely than noncombat veterans (44% in prison and 49% in jail) to have been told they had a mental health disorder.

Furthermore, incarcerated veterans tend to be older, and have a higher rate of divorce than non-veterans who are incarcerated, in addition to being mostly white and male. What does all of this mean? It might suggest that veterans are not your typical incarcerated population and that we should be well prepared to work with them.

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# Learning Objectives and Training Agenda

Time: 10 minutes

## Course Objectives

- Understand the difference between explicit vs. implicit military culture;
- Understand how veteran and military culture may impact a veteran's experience and behavior in the courtroom setting;
- Understand the basics of risk, need, and responsivity;
- Demonstrate active listening skills;
- Understand the landscape of services available for veterans; and
- Understand how the confluence of mental health, substance use, and military experience may lead to interactions with the criminal justice system

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### Instructor:

Let's look at the learning objectives for this course. You can follow along on page 5 of your Participant Manual. After completing this training, you will be able to:

- understand the difference between explicit vs. implicit military culture;
- understand how veteran and military culture may impact a veteran's experience and behavior in the courtroom setting;
- understand the basics of risk, need, and responsivity;
- demonstrate active listening skills;
- understand the landscape of services available for veterans; and
- understand how the confluence of mental health, substance use, and military experience may lead to interactions with the criminal justice system.

## Course Overview



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### Instructor:

This curriculum includes five substantive modules, in addition to this introduction:

1. **Military and Veteran Culture.** Module 1 will familiarize you with some major aspects of military and veteran culture. In the first lesson of the module, you'll get an overview of military structure, service roles, and major aspects of military culture. In the second lesson, which focuses on veteran culture, you'll explore different criteria used to determine veteran status, and discuss challenges associated with the transition from the military back to civilian life, and why some veterans become justice-involved.
2. **Risk Assessment.** Module 2 introduces the risk-need-responsivity model of offender rehabilitation, which holds that therapeutic intervention should be proportional to a veteran's risk of re-offending, as well as targeted toward their specific criminogenic needs. After you have an understanding of the guiding principles of the RNR framework, you will learn how evidence-based assessment can be used to differentiate offenders by risk-level and individual needs.
3. **Mental Health and Substance Use.** Module 3 introduces the ways in which deployment-derived mental health issues and substance misuse affect veterans, including the context in which they experience trauma. Lesson 1: Mental Health gives an overview of common mental health disorders among veterans, their symptoms, and evidence-based treatment approaches. You'll also discover how mental health stigma can serve to prevent veterans from getting the help they need. In Lesson 2: Substance Use, you'll learn about substance use disorders that affect many justice-involved veterans, and related, evidence-based approaches to treatment.
4. **Navigating Veterans' Resources.** Module 4 will guide you through the variety of benefits

and services available to veterans and their families from the Department of Veterans Affairs and other agencies. Lesson 1 discusses the source of the most well-known veterans' benefits, the federal Department of Veterans Affairs. Lesson 2 identifies and explains useful resources outside the federal VA, including state departments of veterans affairs, community-based organizations, and the so-called Big Six veteran service organizations.

5. **Responsivity and Justice-Involved Veterans.** In Lesson 1: Case management, you will learn about the functions and tasks of the case manager and discover how effective case management can improve outcomes for justice-involved veterans. Lesson 2: Responsivity in the Criminal Justice System, covers a variety of topics related to the responsivity issues of veterans, including: veterans treatment courts, procedural justice, domestic violence issues, and corrections-based programming. Lesson 2 also introduces the sequential intercept model for justice-involved veterans, which as you will learn, can help practitioners identify veterans in need, move them away from avoidable contact with the justice system, and into appropriate treatment.

## Activity: Participant Introductions

Time: 35 minutes

### Participant Introductions

In groups of three, share:

- Your name
- Your position, and number of years in the role
- Your professional background
- In your current role, do you work with veterans? In what capacity?
- What you hope to learn during this training
- Your favorite part of your job

Designate one person to introduce their team to the larger group by sharing the team members':

- Names
- Whether they work with veterans and in what capacity
- Favorite parts of their jobs

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#### Instructor:

Now I'd like us to get to know each other. In groups of three, introduce yourself and tell your group a little about yourself. Then designate one person to introduce your group to the larger group, by sharing everyone's name, whether they work with veterans and in what capacity, and favorite parts of their job. This person will want to pay close attention as their group members introduce themselves to one another.



#### Instructor Note:

After 15 minutes of small group introductions, call time. Go around the room and allow the designated person to introduce their group.

If you are not using name cards or nametags, you may want to make note of participants' names during the introductions so that you get to know everyone by name.

# Training Expectations

Time: 20 minutes

Training Expectations

Expectations for the trainers and the training	Expectations for the participants

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## Instructor:

The best way to maximize the learning potential during the training is to set some classroom rules and expectations. Let’s create a list together of some important training rules and guidelines that you think would be fair and helpful. We’ll start with what to expect from the instructor(s) and the training, and then move on to what to expect from participants. I will write these expectations on the flipchart and post them for use throughout the training.



## Flipchart:

Record responses on flipchart.






## Instructor Note:

Create two lists or flipcharts: “Expectations for instructor(s) & training” and “Expectations for participants.”

Note responses on the flipchart and post them in the training room. Be sure to include the following:

### *Expectations for instructor(s) & training*

- take plenty of breaks
- incorporate various learning styles
- be solution-focused, not problem-focused
- make the learning interactive

	<p><i>Expectations for participants</i></p> <ul style="list-style-type: none"> <li>• return from breaks on time</li> <li>• limit side conversations</li> <li>• be solution-focused, not problem-focused</li> </ul>
	<p><b>Instructor:</b></p> <p>Let's take another look at your Participant Manual. On the first page of each module, you will find a module overview, which provides a brief synopsis of the topics covered over the course of the module. Performance objectives for participants define the knowledge and skills you will gain throughout the module. You will be able to assess your level of competency in the knowledge and skills covered in each module by completing each End-of-Module quiz. At the end of each module, you will have ten minutes to complete a quiz. After the ten minutes are up, we will discuss the answers together. These quizzes are included for your own benefit only and are intended to provide you a way to track your progress throughout VICTOR; they will not be collected or graded.</p> <p>You will notice that each module is broken down further, into two or more lessons. On the first page of each lesson, you'll find a lesson preview which like the module overviews, provide a general outline of topics covered in the upcoming lesson.</p> <p>Finally, on the last two pages of each lesson there is room for note-taking. During the training, feel free to use this space to record notes, questions, reflections, or anything else that may be of use to you. You've also been provided the slides with an area to take notes and follow along.</p>
	<p><b>Ask:</b></p> <p>What questions do you have before we get started?</p> <p><b>Anticipated Response:</b></p> <p>Responses will vary.</p>
	<p>Coming up in our first module, we will explore military and veteran culture. But before we begin, you will complete a short, diagnostic self-assessment. This is designed to measure your knowledge of military and veteran culture, as well as your familiarity with veteran risk, need, and responsivity issues. At the end of the course, you will complete the same self-assessment to measure the difference in your knowledge and skills before and after training.</p>

## Diagnostic Self-Assessment

Time: 15 minutes



**Instructor Note:**

At this point, hand out the Diagnostic Self-Assessments. Give the group 15 minutes to fill them out independently and then collect them at the end. Save them in an envelope until the end of the course.



**Instructor:**

The diagnostic self-assessment is divided into two sections, or subscales. The first is designed to assess knowledge of military and veteran culture, while the second measures your confidence in your own responsivity skills related to veteran issues. For both subscales, review each statement in the first column and circle the number that best describes your level of agreement based on the rating scale provided. Be candid in your responses as this self-assessment process is an opportunity to identify your own strengths and areas for potential growth. Take 15 minutes to complete the assessment, and then hand it in to me. We will complete the same assessment at the end of the whole curriculum to measure your learning.

## Break

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# Module 1: Military and Veteran Culture

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**Time: 3 hours, 45 minutes**

## Module Overview

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For all veterans, the culture of the military plays a significant and lifelong role in rehabilitation and the transition back to civilian life. To work effectively with justice-involved veterans, it is critical to understand the ways in which military culture may impact a veteran's thoughts, feelings, and behaviors. This module will provide information and insights into explicit and implicit aspects of military and veterans' culture. Lesson 1: Military Culture, contains an overview of military structure, service roles, and major aspects of military culture. Lesson 2: Veteran Culture begins by posing the deceptively simple question, "Who is a veteran?" Once participants have considered the different criteria used to determine veteran status, they will learn about the transition from military to civilian life and why some veterans become justice-involved.

### Goals for the Instructor

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- Introduce participants to military structure, branches, and missions
- Help participants understand the transition from military to civilian life
- Build an understanding of how military culture can affect a veteran's behavior and lead to justice involvement

### Performance Objectives for Participants

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- Gain fluency in military and veterans' culture, including a better understanding of military structure, branches, and missions
- Recognize the issues related to military service that may contribute to a veteran's involvement in the criminal justice system
- Understand some of the challenges of transitioning from military to civilian life

### References and Recommended Reading

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Bellavia, D., & Bruning, J. R. (2007). *House to House: An Epic Memoir of War*. New York: Free Press.

Kraft, H. S. (2012). *Rule Number Two: Lessons I Learned in a Combat Hospital*. New York: Back Bay Books.

Military websites:

- <https://www.army.mil>
- <http://www.marines.mil>
- <http://www.navy.mil>
- <http://www.af.mil>

## Lesson 1: Military Culture

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### Lesson Preview:

Military service is a profound experience that many civilians do not understand. This lesson gives an overview of the structure of the military, including branches, missions, and service roles, as well as elements of military culture, such as boot camp, discipline, duty, honor, and issues faced by women in service. The information contained in this lesson will help participants develop increased awareness of military culture, and the unique ways that military ideals and core values continue to impact veterans long after service ends.

### Topics:

- Overview of Military Structure (25 minutes)
- Categories of Military Personnel (20 minutes)
- Recruit Training (10 minutes)
- Cultural Elements of the Military (60 minutes)
- Women in the Military (15 minutes)
- Conclusion (5 minutes)

**Total Instruction Time:** 2 hours, 15 minutes

## Overview of Military Structure

Time: 25 minutes

### Overview of Military Structure

- Branches:
  - Structure
  - Missions
- Service roles:
  - Active duty
  - Reserves
  - National Guard
  - Job types

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#### **Instructor:**

To begin this lesson, we will go over an introduction to military service, including branch structure, missions, and service roles.

To provide culturally competent services for justice-involved veterans, we must be mindful of the differences and unique aspects of each branch and role within the armed forces.

## Overview of Military Structure



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### Instructor Note:

The Marine Corps and the Navy report to the Department of the Navy, even though they are distinct branches under the Department of Defense. The Marine Corps is led by the Commandant; the Navy is overseen by the Chief of Naval Operations.



### Instructor:

Most military service branches operate under the U.S. Department of Defense, or “DoD,” whose mission is to deploy military forces to deter war, engage an enemy in foreign lands, perform peacekeeping missions, all to protect the security of the United States. Shown here are the different branches of the armed forces, including the Army, Marine Corps, Navy, and Air Force. You’ll notice that the Marine Corps and the Navy use a Department of the Navy seal. This is because both fall under the Department of the Navy, although each has its own autonomous leadership.

## Overview of Military Structure



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### Instructor:

A separate—and the smallest—branch of the military is the United States Coast Guard and its Reserve component, which play a role in maritime safety, security, and stewardship. The Coast Guard operates under the U.S. Department of Homeland Security during peacetime, but can be transferred to the Department of the Navy by the President at any time, or by Congress during times of war.

## Branch Missions

The **Army's** mission is to deploy arms and materiel to provide prompt, sustained land dominance across the full range of military operations and spectrum of conflict following the directives of commanders.

The **Marine Corps** mission is to train, organize, and equip for offensive deployment, often in amphibious assaults, and as a force in readiness.

The **Navy's** mission is to maintain, train, and equip combat-ready naval forces so they are capable of deterring aggression, winning engagements with an enemy, supporting ground forces, and maintaining freedom of the seas.

The mission of the **Air Force** is to fly, fight and defeat an enemy in air, space, and cyberspace, as well as to engage in missions in support of ground forces.

The mission of the **Coast Guard** is maritime safety, security, and stewardship. It is assigned to the Department of Homeland Security, except under wartime when it is under the operational control of the Navy.

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### Instructor:

Now that we have reviewed the structure of the military, we will take a closer look at the mission of each branch.



### Instructor Note:

Do not read each mission aloud.



### Ask:

Take a minute to look over these missions.

What similarities do you notice? Differences? How might certain qualities of one branch influence behavior of a service member differently than another branch?

### *Anticipated Responses:*

Most contain similar language about fighting and winning; different means of fighting; different training, land, air, or sea, might make someone more specialized/dedicated to one type over another; Marines might feel superior because they're

amphibious; Coast Guard might feel inferior because they're under a different department; difference between offensive and defensive forces.



**Instructor Note:**

Allow the participants to contribute answers and facilitate a short discussion about perceived differences of each branch.

## Categories of Military Personnel

**Time: 15 minutes**

### Categories of Military Personnel

- Active duty
- Reserves (for each branch)
- National Guard
- Job types



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**Instructor:**

Now that we've had an overview of the branches of the military, we will discuss the difference in categories of personnel. Understanding the difference between the types of military service can help us gain more insight into the background and experiences of veterans. We will take time to review key aspects of each.

## Active-duty Service



- Full-time service, 24/7
- Applicable to any branch

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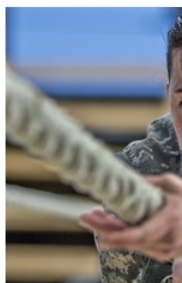


### **Instructor:**

Active-duty service refers to full-time service in the armed forces. These members are available for duty 24 hours a day, 7 days a week, with the exclusion of leave (or vacation) or a pass, which is authorized time off a military base. Active-duty members serve in the Army, Air Force, Navy, Marine Corps, and Coast Guard, or in a Reserve unit called up and deployed.

## Reserves

- Part-time service
- Each branch has a reserve component
- Under Department of Defense



### **Instructor:**

Members of the Reserves and National Guard are considered part-time, typically performing duties one weekend per month plus two weeks of training per year. The objective of the Reserves is to deliver supplementary support to active-duty forces, when obligated. All the branches have Reserve components: Army Reserve, Air Force Reserve, Navy Reserve, Marine Corps Reserve, and Coast Guard Reserve.

## National Guard

- Army National Guard
- Air National Guard
- Mostly under state control



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### Instructor:

In addition to the Reserves, there are two National Guard types: The Army National Guard and the Air National Guard. Like the Reserves, National Guard members attend basic training and military job school full-time while under active-duty for training, or “ADT.”

The biggest difference between the National Guard and the Reserves is that the federal government oversees the Reserves, while the National Guard units are under the auspices of individual states. Like the Reserves, they maintain daily civilian life but train one weekend per month in addition to 15 full-time training days per year.

Additionally, state governors can call National Guard members to active-duty if a state emergency arises. Emergencies may include relief or protection of property and people outside the authority of local law enforcement, as during an earthquake, major weather event, or riot. This form of state duty is known as “Title 38 Call-up.” The President and Secretary of Defense can also summon the National Guard for federal duty, known as “Title 10 Call-up.”

Why are we talking about Call-ups? Over the next few days, we’re going to spend a lot of time talking about services and benefits available to veterans. Many factors impact a veteran’s eligibility for benefits, including the nature of their service. For example, National Guard service typically does not confer benefits, unless the service member performed Title 10 Call-up service. This is one example of the nuances of veterans’ service eligibility, which we will learn about in more detail later.

## Job Types



- Hundreds of different specialties for each branch
- Hundreds of non-combat positions

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### **Instructor:**

It's also important to keep in mind that there are hundreds of different job types/careers in each branch of the military. These job roles include truck drivers, mail clerks, band officers, kitchen staff, military police, information specialists, doctors, nurses, communications specialists, and hundreds of other job types. For every combat soldier, there are many support personnel, who may also be seriously affected by war and military culture—for example by witnessing grave injuries to their fellow servicemembers.

## Recruit Training

Time: 10 minutes

### Recruit Training (“Boot Camp”)

- In every branch, volunteer recruits attend basic training courses
- Training centers are located throughout the country
- Intensity and length vary



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#### **Instructor:**

Recruit training is an experience that all members of the military undergo before beginning their service. Recruits are young men and women who have voluntarily enlisted, and are transitioning into military culture.

Each unit of the military has its own version of recruit, or basic, training, at centers located throughout the country. Training is typically segmented into phases, including fitness, basic combat, academic classes, and a variety of specialized subjects.

The length of time a recruit attends boot camp varies, depending on the military branch. Military boot camps offer high-intensity training programs to equip recruits with the adequate knowledge, skills, and discipline necessary to serve.

In addition to building physical strength and specialized skill sets, boot camp serves to initiate new recruits into military culture. Boot camp builds the camaraderie among recruits that is central to the military experience.



#### **Ask:**

Have you ever attended a boot camp or similar intense period of training? If so, what was it like for you? How did you feel afterwards?

#### **Anticipated Responses:**

Yes, tired; proud; stronger than before I did it

## Break

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## Cultural Elements of the Military

Time: 60 minutes

### Discussion Questions

- What is culture?
- How does culture shape behavior?



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**Instructor:**

Now that we understand the structure of the military, categories of military personnel, and boot camp, we will shift to discussing the unique features of military culture.



**Ask:**

To begin, in general, what is culture?



**Flipchart:**

Write participants' answers on a flipchart.



**Instructor Note:**

Use participant answers to create a shared understanding of "culture" on the flipchart.



**Ask:**

Now that we have a shared understanding of culture, how can culture shape behavior?

***Anticipated Responses:***

Cultural norms regulate behaviors in certain spaces; culture can restrict behavior or enable it; people act in accordance with cultural norms



**Instructor Note:**

Facilitate discussion about above question; do not write answers on flipchart.



**Instructor:**

In this discussion, we've touched upon explicit aspects of culture, like obvious, written, or stated rules, regulations, and qualities that a group shares. We also discussed the *implicit* nature of culture, or the underlying values, attitudes, and beliefs that can also regulate a person's behavior and lifestyle. It is important for us to keep this explicit/implicit distinction in mind for the following discussion.

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## Discussion Question

- Based on your own knowledge, what are cultural elements of the military?



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### Discussion Group:

Living in the United States, we have likely been exposed to images, ideas, and stereotypes of military culture. Find a partner and discuss: What do you think are some aspects of military culture?



### Instructor Note:

If possible, pair up veterans and non-veterans. Allow 5 minutes for conversation.



### Ask:

Now we will share our partner conversations with the larger group. What aspects of military culture did you come up with?

### Anticipated Responses:

Respect; honor; dignity; hyper-masculinity; discipline; courage; commitment; tradition; ceremony; camaraderie



### Flipchart:

Write answers down on flipchart.



### Ask:

Now, let's decide from this list: which are *explicit* cultural elements, and which are *implicit* cultural elements?



### Flipchart:

Go to flipchart, and go through each response to determine if an element is implicit or explicit by tallying a hand-raise vote from the group. Mark down each as implicit or explicit.



**Instructor:**

As we discussed earlier, *explicit* aspects of culture – stated rules, clear traditions, and other visible markers like uniforms, signage, codes, and badges – create norms and standards that can foster certain *implicit* attitudes, expectations, and behaviors.

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## Some Mottos of the Armed Forces

- “Duty, honor, country” (Army)
- “Semper fidelis” (“Always faithful”) (Marine Corps)
- “Always ready, always there” (National Guard)
- “Not self, but country” (Navy)
- “Aim high...fly, fight, win” (Air Force)

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### **Instructor:**

We have just generated a list of elements of military culture on our own. Because different generations of men and women served in different wars in a variety of countries, with a variety of missions, roles, and circumstances, it’s important to keep in mind that culture is ever-evolving, and there is not one definitive set of features.

Listed here are a few mottos of units of the armed forces. These can be interpreted as explicit statements that encapsulate the culture of each service. As we can see, themes include duty, loyalty, and commitment to our country.

We have learned the implicit cultural elements can be borne of these explicit statements.



### **Instructor Note:**

Do not read each motto aloud.

## Implicit Cultural Elements of the Military

- Discipline
- Strength > weakness
- Respect
- Emotional restraint
- Hyper-vigilance
- Esprit de corps (strong group bond)



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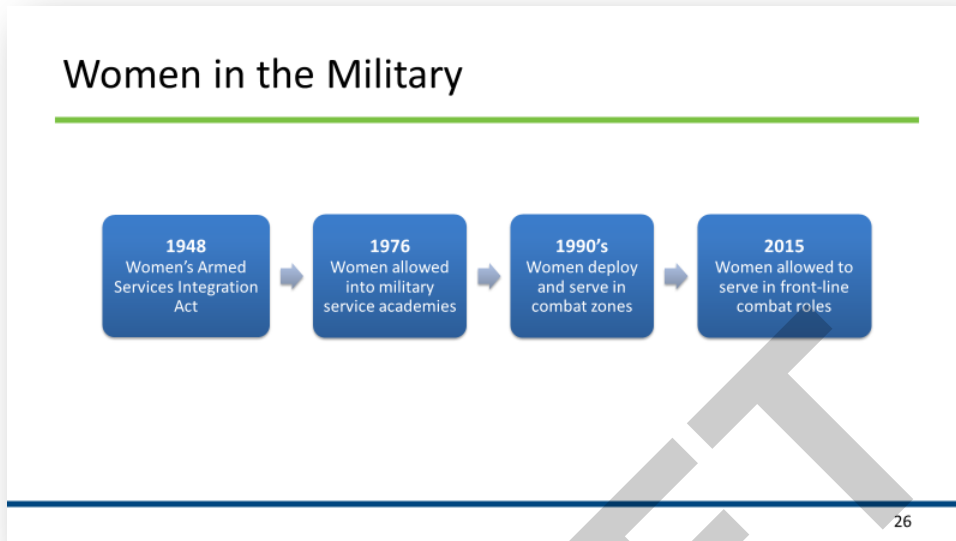
### Instructor:

Those who study the military typically cite the factors listed on the slide as *implicit* cultural elements. These attributes are important to understand because they are intangible and thus may not always be immediately recognized, but can still influence behaviors, expectations, or attitudes of veterans. Those who work with veterans should be on the lookout for behaviors and attitudes that reflect these implicit cultural elements.

These cultural elements develop during a service member's time in the military, from basic training through deployment. Many of these factors, such as discipline, strength, emotional restraint, and hyper-vigilance, are key to a service member's physical and emotional survival. Service members utilize hyper-vigilance to remain aware of their surroundings in dangerous situations. Esprit de corps describes the brotherhood and sisterhood of the military and the strong bond that forms over time and can last a lifetime. For example, the mottos we discussed on the last slide capture the spirit of fighting for one's country. However, you might notice when you're talking to veterans that many service members report that they fight for their fellow soldiers—even above fighting for their country.

# Women in the Military

Time: 15 minutes



## Instructor:

Women and men in the military are subject to the same cultural elements, like discipline, strength, and emotional restraint, as we previously discussed. These elements are largely developed by and cater to the behaviors, attitudes, and values of men. Because women's integration into the armed forces is relatively recent, the culture has not caught up with the reality of the roles played by women in just about every facet of the military.

Let's review the recent history of women in service to understand the context in which they currently serve. We will review other relevant issues related to women's service later in the training.

In 1948, women were officially allowed to serve as permanent, regular members of all branches of the armed forces, through the Women's Armed Services Integration Act, signed into law by President Harry S. Truman, who also integrated our nation's armed forces.

Another milestone came in 1976 when women were first allowed to attend the U.S. Military Academy at West Point, the Naval Academy at Annapolis, and the Air Force Academy in Colorado Springs.

Throughout the 1990s, women were deployed and served in combat zones. In 2016, women were officially allowed to serve in front-line combat roles, although several positions are still only available to men.

## Women in the Military

- Sexual harassment
- Military sexual trauma (MST)

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### **Instructor:**

In part because of the hyper-masculine, violent, and isolating nature of the military, many men as well as women have experienced sexual harassment and military sexual trauma, or MST. This acronym alludes to sexual harassment or sexual assault that occurs while someone is on active-duty or in training. One in 5 women have self-reported that they have experienced MST; one in 100 men have reported the same. Keep in mind that exact numbers are difficult to discern.

This experience can have many ramifications for the victims, as do other types of trauma. Because the rates of sexual trauma are higher in the military than among women in the general population, it is important to be aware of how prevalent and pervasive MST is for the veterans we encounter. In addition, because there is a high value placed on strength, self-sufficiency, and loyalty, some effects of sexual harassment and assault can be compounded for veterans. We will discuss the effects of trauma in a future section.

## Conclusion

Time: 5 minutes

### Conclusion: Military Culture

- Elements of military culture may create conditions for certain behaviors of veterans
- Important to understand these cultural elements for our work in the justice system

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#### Instructor:

Now that we have reviewed the structure of the military, including branches, missions, and service roles, as well as elements of military culture, including boot camp, discipline, duty, honor, and women's issues, we can use this knowledge to inform our work with veterans in the justice system. We can use this understanding in our interactions with the veterans we encounter to build a rapport, and better analyze certain attitudes or behaviors. We'll now take a break, and then transition into learning about the culture of veterans.

## Lunch Break

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## Lesson 2: Veteran Culture

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### Lesson Preview:

In Lesson 2, participants delve into the implicit and explicit aspects of veteran culture and discuss varying criteria for what makes someone a veteran. Related to the question of what qualifies someone with veteran status, this lesson explains how criminal justice professionals can, and should, be identifying veterans at all stages of criminal justice processing. Participants will learn about different types of veteran discharge status, and the relationship between discharge status and benefits eligibility. Finally, participants will begin to examine some of the challenges veterans face when they transition from the military back to civilian life.

### Topics:

- Introduction to Veteran Culture (15 minutes)
- Who is a Veteran? (5 minutes)
- Vietnam Veterans (10 minutes)
- Iraq/Afghanistan Veterans (10 minutes)
- Types of Discharges (15 minutes)
- Reunion and Reintegration (10 minutes)
- Skills Building: Veteran Identification (20 minutes)
- Conclusion (5 minutes)

**Total Instruction Time:** 1 hour, 30 minutes

## Introduction to Veteran Culture

Time: 15 minutes

### Implicit Cultural Elements of the Military

- Discipline
- Strength > weakness
- Respect
- Emotional restraint
- Hyper-vigilance
- Esprit de corps (strong group bond)

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**Instructor:**

Now that we've had a break, we are going to transition into talking about the types of veterans we encounter in our work: people who come to us because of their involvement in the justice system. Let's start with an exercise about how culture might influence the behaviors of justice-involved veterans. For example, a veteran who is hyper-vigilant might sit near the back of the courtroom to have a better vantage point.



**Instructor Note:**

Do not read each cultural element aloud. Allow 5-10 minutes for partner discussion.



**Ask:**

Turn to the person next to you and discuss: What are other examples of justice-involved veterans' behaviors that might be explained by these cultural elements?

***Anticipated Responses:***

Veterans that don't ask for help or assistance because of fear of looking weak; standing at attention for the judge.



**Instructor:**

These examples are important to keep in mind when working with this population in court and in healthcare settings. Now, let's learn more about how military culture can influence veterans' behaviors, and why it's important to understand how this can and often does occur.

## Who is a Veteran?

Time: 5 minutes

### Veteran Culture

- Who is a veteran?
  - Common understanding
  - Federal regulations



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#### **Instructor:**

Let's begin our lesson on veteran culture, by asking a deceptively simple question: who is a veteran?

#### **Anticipated Responses:**

Veterans are former military members; veterans are anyone that served in the armed forces



#### **Instructor Note:**

Let participants contribute answers and discuss as a group.



#### **Instructor:**

There are varying understandings of what makes someone a veteran. In general, a veteran is anyone who served on active-duty for any amount of time beyond training in any branch of the armed forces.

When it comes to eligibility for veterans' benefits, including health care and disability compensation, federal regulations, recognized by the VA, define a veteran more narrowly as a person who served in the active military, naval, or air service and who was discharged or released from the military under conditions other than dishonorable. Recent changes in the law also convened veteran status on certain members of the Reserves and National Guard who served twenty or more years; their status, however, does not necessarily make them eligible to receive veterans' benefits, however.

## Vietnam Veterans

**Time: 10 minutes**

## Vietnam Veterans

- What do you think you know about Vietnam veterans?



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### Instructor:

We've started to define the word veteran, but when I say the word "veteran," each of us may nevertheless have a different perception of who that person is. A large part of that is because veterans from different periods of military conflict *do* look different and have had very different experiences.



### Ask:

For example, what do you think you know about veterans from the Vietnam war?

### *Anticipated Responses:*

Older; not that many still alive; patriotic; were under-appreciated



### Flipchart:


Write answers to prompt on flipchart.



### Instructor Note:

Facilitate whole group conversation and record answers on flipchart. After the group is done giving responses, highlight the ones that may be misconceptions, and note any of the following characteristics that may have been missed:

- Average age: 71 years old
- Out of military 45 years or more
- Empty nesters - grandparents
- Usually one tour of duty
- Fewer in direct combat role
- Possibly married/divorced (multiple times)
- Considering retirement or unemployed/disabled

	<ul style="list-style-type: none"> <li>○ Severe physical illnesses</li> <li>○ Some are still homeless</li> <li>○ Chronic PTSD</li> </ul>
	<p><b>Instructor:</b></p> <p>It's important for us to add some context to these characteristics. During the years of the Vietnam war (1959-1975), more than 27 million American men came of draft age. Some nine million served in the military and of these, some three million were deployed to the Vietnam area of operations. Today, some eight million who served in the Vietnam era are still alive. Many of these veterans continue to battle with the effects of war, such as PTSD. The commonly cited suicide rate of veterans, approximately 20 per day, are accounted for mostly by this group (two thirds). Now let's think about a different group of veterans—those who fought in the more modern operations in the Middle East.</p>

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## Iraq/Afghanistan Veterans

Time: 10 minutes

### OEF/OIF/OND Veterans

- Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn
- What do you think you know about Iraq/Afghanistan veterans?



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#### Instructor:

Now that we understand some of the characteristics and experiences of Vietnam veterans, we will spend time reviewing the context of the experiences of veterans of the Iraq/Afghanistan wars.



#### Ask:

What do you think you know about Iraq/Afghanistan veterans?

#### **Anticipated Responses:**

Younger; many deployments; PTSD; substance users



#### Flipchart:



Write answers to prompt on flipchart.



#### Instructor Note:

Facilitate whole group conversation and record answers on flipchart. After group is done giving responses, highlight the ones that may be misconceptions, and note any of the following characteristics that may have been missed:

- Average age: 25-29
- Out of military 0-10 years
- Not married or have young families
- Going to school, work, and planning career
- Living with parents or roommates or homeless
- More time in war zone; more direct combat participation per person
- Fewer soldiers = multiple deployments to war zone\*

	<ul style="list-style-type: none"><li>○ Higher wound survival rate</li><li>○ High rate of suicide</li><li>○ Acute PTSD</li></ul>
	<p><b>Ask:</b></p> <p>Why do you think we did this exercise?</p> <p><b><i>Anticipated Responses:</i></b></p> <p>To highlight the differences between different eras of combat; to show that veterans come in all shapes and sizes;</p>
	<p><b>Instructor:</b></p> <p>That's right! But also, we must keep in mind that regardless of these major demographic differences, all veterans have a shared culture.</p>

# Types of Discharges

Time: 15 minutes

## Types of Discharges

- Honorable
- General – under honorable conditions
- Other than honorable
- Bad conduct
- Dishonorable

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### Instructor:

When somebody leaves active military service, they are discharged by their branch of the armed forces. An important aspect of veterans' culture is discharge status, and the implications of each type of discharge. There are five types of military discharge. The quality of one's active-duty service determines the type of discharge he or she receives, which is noted on their DD-214 form, which we will discuss in more detail later. Conversely, if you know a veteran's discharge status, you already understand a little bit about their experience in the military during active-duty.

The five military discharges are honorable, general, other than honorable, bad conduct, and dishonorable. These are important to understand, not only to obtain insight into the veteran's military experience, but also to help determine eligibility status for VA benefits. There are many different factors that determine eligibility for VA benefits, such as length of service and income, and we will talk about this in more detail in the Navigating Veterans' Resources Module. Let's take a few minutes to review each type.

An *honorable discharge* is given when the service member completed his or her duty with admirable personal and professional conduct. Veterans with an honorable discharge are more likely to be eligible for many benefits. They may also have an easier time finding employment since an honorable discharge reflects well on a resume.

A *general discharge* denotes that a service member completed his or her service with less than honorable circumstances during duty or upon discharge. Conditions such as illness, injury, or other determinants lead to a general discharge. An unacceptable but non-judicial

behavior such as drug abuse initiates a general discharge as well.

A judgment of *other than honorable* occurs when a military member's conduct includes violence, security violations, or he or she is in trouble with the civilian court system, for reasons such as a felony conviction. Other than honorable is the most severe of the administrative discharges because it bans people from ever reenlisting into any branch of the armed forces.

*Bad conduct discharge* is a punishment for a military crime. It is given only through a court martial, and typically results in confinement to a military prison for a short period of time.

A *dishonorable discharge* is also a punitive action against a military member. Serious offenses such as murder or desertion of duty will cause a court-martial to order a dishonorable discharge. Veterans with a dishonorable discharge might be ostracized from the military community and often have a hard time finding employment. They are also not eligible for most VA benefits.

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## Determining Discharge Status

- **DD Form 214**

- Department of Defense issues this paperwork to every veteran
- Contains information needed to verify military service for benefits eligibility or membership in a variety of veterans' organizations
- Can access an electronic copy for free from:
  - [www.vetrecs.us](http://www.vetrecs.us)
  - <https://www.ebenefits.va.gov/ebenefits/manage/documents>
  - National Personnel Records Center (mail, fax, in person)

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**Instructor:**

Veterans all receive discharge paperwork from the Department of Defense that denotes essential information about their time in the military, such as their discharge status, branch, duty assignments, primary specialty, length of service, medals/badges, and reasons for separation. This paperwork is called a DD-214 form, and contains information needed to verify eligibility for various benefits or veterans' organizations. These forms can be accessed as an electronic copy from the websites listed here, or in person or by mail or fax from the National Personnel Records Center.

# Reunion and Reintegration

Time: 10 minutes

## Reunion and Reintegration

- Reunion
  - Return to home life
- Reintegration
  - Barriers to employment, education, etc.
  - Emotional/psychological state of mind
- Potential for justice-involvement

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### Instructor:

Now that we have a better understanding of the meaning of the term “veteran,” and the significance of their discharge status, let’s talk about what it means to transition from military to civilian life and why some veterans become justice-involved. Although most veterans transition well, others struggle.

While our military does a top job training our service members, the military doesn’t do nearly as well preparing them for their return to the civilian world. In many cases, coming home from a deployment can be challenging for veterans, as well as their family and friends. Veterans must manage both returning to their home life, as well as reintegrating into multiple facets of civilian life.

Among other issues, returning to one’s previous role in the household dynamic may prove challenging. Both the veteran and members of the household must adjust to a renewed way of life. The deployed service member has primarily focused their recent time on their military job, and returning to be a contributing member of the household is not always smooth. It’s important to keep in mind that a veteran’s home life might be challenging in the short-term. Also consider that many veterans do not have a family or home to return to.

Many veterans emerge from the military with valuable skills that can transfer to the civilian job market and most veterans find employment after their service. However, veterans often encounter challenges reintegrating into a variety of aspects of social life. For example, a veteran might have difficulty finding employment, which as we will learn in a later module, can be a risk factor for justice involvement. One reason veterans may have

difficulty finding employment is due to physical injuries that may make them ineligible for jobs that require physical work. Another reason is that mental health issues, particularly traumatic brain injury, or TBI, can be a major impediment to attending school or getting a job. Because TBI inhibits concentration and causes memory-related deficiencies, many veterans afflicted with TBI find the stress of college or job unbearable. Treatment for TBI takes time and requires a good support system to overcome the injury.

Additionally, many veterans will file disability claims and may wait many months for the VA to adjudicate their claim. During this time, because a veteran may not be able to work or attend school, they may have no income. Without an income, the veteran may turn to illegal ways to make money, which can lead to justice involvement. Understanding the variety of factors that affect reintegration can help us to better serve justice-involved veterans.


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## Skills Building: Veteran Identification





Time: 20 minutes



### Skills Building: Veteran Identification


- Screen early and screen often
- “Have you ever served in the Armed Forces of the United States?”



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	<p><b>Instructor:</b></p> <p>As criminal justice professionals, it’s important that we all play a role in identifying veterans and active-duty military who come through the court system. Identifying veterans is important because it allows us to link the person to specialized services and programs, and it gives us important context for understanding their experience within the criminal justice system.</p>
	<p><b>Ask:</b></p> <p>What do you think is the best way to ask if someone is a veteran?</p> <p><b>Anticipated Responses:</b></p> <p>“Are you a veteran?”</p> <p>“Have you ever served in the military?”</p> <p>“Are you a military veteran? Remember, combat or deployment are not required to be considered a veteran.”</p>
	<p><b>Instructor:</b></p> <p>It is important for screeners and assessors to clarify that deployment or combat are not prerequisites for identifying oneself as a veteran. That’s why asking if someone has ever “served in the Armed Forces of the United States” is generally considered to be the best way to ask. Phrasing the question this way will also help to identify active-duty military.</p>
	<p><b>Ask:</b></p> <p>When should criminal justice professionals inquire whether an individual is a veteran?</p> <p><b>Anticipated Response:</b></p>

	<p>As soon as they enter the criminal justice system; as soon as they are arrested and booked; at every subsequent stage in the system.</p>
	<p><b>Instructor:</b></p> <p>Correct. Individuals should be screened for veteran status as soon as they enter the criminal justice system, and at every subsequent stage in criminal justice processing. A person's status as a veteran could be helpful for reducing the severity of the criminal charge(s), helping them to secure bond or pretrial release from detention, helping them access needed treatment or rehabilitation services, and/or diverting them from receiving a criminal record or a sentence of incarceration.</p> <p>For example, upon arrest, members of the sheriff's department, pretrial services agency, or probation department should inquire of each arrestee whether he or she has ever served in the Armed Forces of the United States. Likewise, judges, attorneys, and other justice system personnel should ask the question at all stages in the criminal justice system, including when pretrial release decisions are being made, during plea negotiations, at trial, during sentencing, and at the point of reentry from jail or prison.</p> <p>Importantly, some individuals are reluctant to disclose their military status because they may fear losing VA benefits, appearing weak, receiving an unfavorable mark on their service record, or bringing dishonor to their unit. Therefore, it is critical to inquire repeatedly whether someone served in the armed forces at every stage in the justice system to increase the odds of reliable reporting. It is also important to provide assurances that this information will be used to help them access needed services, and will not blemish their service record.</p> <p>Not all individuals may recognize themselves as being a veteran. A person can be a veteran even if they were not deployed to another country or military theatre of operations, did not serve during a period of war or conflict, and/or did not experience combat. As we discussed earlier, the VA has its own definition of "veteran" which relates to benefits eligibility. But many social services programs or support groups welcome all different types of veterans, not just those who meet the VA definition.</p>
	<p><b>Ask:</b></p> <p>What else should you ask once someone has confirmed their service?</p> <p><b><i>Anticipated Responses:</i></b></p> <p>"What service branch were you in?"</p> <p>"What was your rank?"</p> <p>"What did you do in the military?"</p> <p>"Have you served our country in uniform?"</p> <p>"What type of discharge did you receive?"</p> <p>"Can I connect you to benefits or services?"</p>

	<p>“Have you determined if you were eligible for VA benefits?”</p> <p>“Are you connected to VA benefits?”</p> <p>“Thank you for your service!”</p>
	<p><b>Instructor:</b></p> <p>These are all important questions to ask and can be tremendously useful in case planning. Please keep in mind that not all veterans feel the same way towards their time in the service, so phrases like “thank you for your service” should be used with your best judgement.</p> <p>Ideally, once somebody has been identified as a veteran or active-duty military personnel, additional brief screening tools should be administered to rule out serious mental health or substance use disorders that are commonly found among justice-involved veterans. Of course, whether this process can be implemented in your jurisdiction depends on the availability of suitable resources.</p> <p>As we will cover in an upcoming module, PTSD, TBI, major depression, and substance use disorders are prevalent among justice-involved veterans. These afflictions can have serious repercussions for an arrestee’s safety and welfare, may require immediate treatment or intervention, and could impact that person’s criminal case. Therefore, these conditions should be screened for as soon after arrest as possible. We’ll talk about this more in Module 3.</p>

## Conclusion

Time: 5 minutes

### Conclusion

- Structure
- Culture
- Veterans' challenges and strengths
- Identifying veterans in the criminal justice system

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#### Instructor:

While our military does a great job of training our service members for their military occupational specialty, many veterans feel it does an insufficient job preparing them to return to the civilian world. Service members in the line of duty are an asset; they have a mission, and a purpose. But once the term of enlistment ends, service members who do not choose to re-enlist return to the civilian world where their military training and their experiences in a war zone are not always compatible with thriving as a private citizen.

This module has provided an overview of the structure of the military, cultural elements of the military, an introduction to issues facing some veterans, and information about screening for veteran status. With this knowledge, we hope you will be better able to effectively relate to, understand, identify, assess, judge, defend, or prosecute veterans. In Module 3, we go on to discuss how to accomplish this in more detail.

## Module 1 Quiz

**Time: 15 minutes**

1. What five branches make up the U.S. Armed Forces?

*The five branches that make up the U.S. armed forces are the Army, Navy, Marine Corps, Air Force, and Coast Guard.*

2. How does an active-duty service role differ from service in the Reserves or National Guard?

*A servicemember who is active-duty is in the military full time. They work for the military full time, 24 hours, 7 days a week, and can be deployed at any time. Individuals in the Reserve or National Guard are not full-time active-duty military personnel, although they can be deployed at any time should the need arise.*

3. What are the five types of military discharge, and why is a veteran's discharge status important?

*The five military discharges are honorable, general, other than honorable, bad conduct, and dishonorable. A veteran's discharge status is important for obtaining insight into the veteran's military experience, and determining eligibility status for VA benefits.*

4. What are two reasons that veterans might have difficulty finding employment upon reentering the civilian job market?

*One reason veterans may have difficulty finding employment is due to physical injuries that may make them ineligible for jobs that require physical work. Another reason is that mental health issues, particularly traumatic brain injury, or TBI, can be a major impediment to getting a job. Because TBI inhibits concentration and causes memory-related deficiencies, many veterans afflicted with TBI find the stress of a job unbearable.*

5. True or false: Individuals should be screened for veteran status as soon as they enter the criminal justice system, and at every subsequent stage in criminal justice processing.

**TRUE**

**FALSE**



**Instructor:**

Before moving on to Module 2, you will complete a short quiz assessing your knowledge of the topics and themes covered in Module 1. You will have 10 minutes to complete the quiz.



**Instructor Note:**

Set timer for 10 minutes. When time is up, take five minutes discuss participants' responses to the quiz questions, and clarify any misunderstandings if necessary.



**Answer Key:**

Instructor answer key provided above.

# **VICTOR DAY 2**

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# Module 2: Risk Assessment

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**Time: 3 hours, 20 minutes**

## Module Overview

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This module give participants an overview of the research that drives concepts and expectations around risk of recidivism for justice-involved veterans. In Lesson 1: Risk, Need, and Responsivity, participants begin to learn how evidence-based screening and assessment can help differentiate offenders both by their future risk of re-offending and their unique needs. During the remainder of Lesson 1, participants learn through independent study, group discussions, and activities about risk-need-responsivity theory (RNR). In Lesson 2: Risk Assessment for Veterans, participants will learn about using RNR and risk assessment in the context of their work with justice-involved veterans.

### Goals for the Instructor

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- Provide a practical overview of the research literature on RNR
- Assist participants in understanding the basic tenets of RNR and applying those concepts in day-to-day practices with justice-involved veterans
- Help participants understand the importance of using research instead of intuition alone to inform and drive decision-making.

### Performance Objectives for Participants

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- Demonstrate an understanding of risk, need, responsivity theory
- Identify the most influential risk factors and criminogenic needs among military veterans
- Demonstrate an understanding of the risk principle and the need principle by utilizing risk and need information to develop evidence-based case plans
- Identify commonly used risk and need assessment tools in the criminal justice system, and how those tools may be used with veterans

### Reference and Recommended Reading

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## Lesson 1: Risk, Need, and Responsivity

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### Lesson Preview:

The risk-need-responsivity (RNR) model is an evidence-based approach to offender assessment, treatment, and rehabilitation. This lesson begins by highlighting functional differences between screening and assessment and next, introduces the RNR model. The implications of this model for practitioners are discussed, including how it can be used to identify appropriate intervention strategies and treatment programs for justice-involved veterans. By the end of the lesson, participants will understand the central principles of risk, need, and responsivity that make up the RNR framework, and discover how adherence to these principles can promote positive treatment outcomes in justice-involved veteran populations.

### Topics:

- Foundations of Screening and Assessment (10 minutes)
- Screening v. Assessment (5 minutes)
- Overview of Risk-Need-Responsivity Theory (10 minutes)
- The Risk Principle (15 minutes)
- The “Big Eight” Criminogenic Risk Factors (10 minutes)
- The Need Principle (10 minutes)
- The Responsivity Principle (10 minutes)
- Predicting Recidivism: Clinical v. Actuarial Decision-Making (30 minutes)
- Examples of Actuarial Risk Assessment Instruments (10 minutes)


**Total Instruction Time:** 1 hour, 50 minutes

# Foundations of Screening and Assessment





Time: 10 minutes




## Foundations of Screening and Assessment

- *What* do we want to know about people?
- *Why* do we want to learn about people?
- *How* can we learn about people?



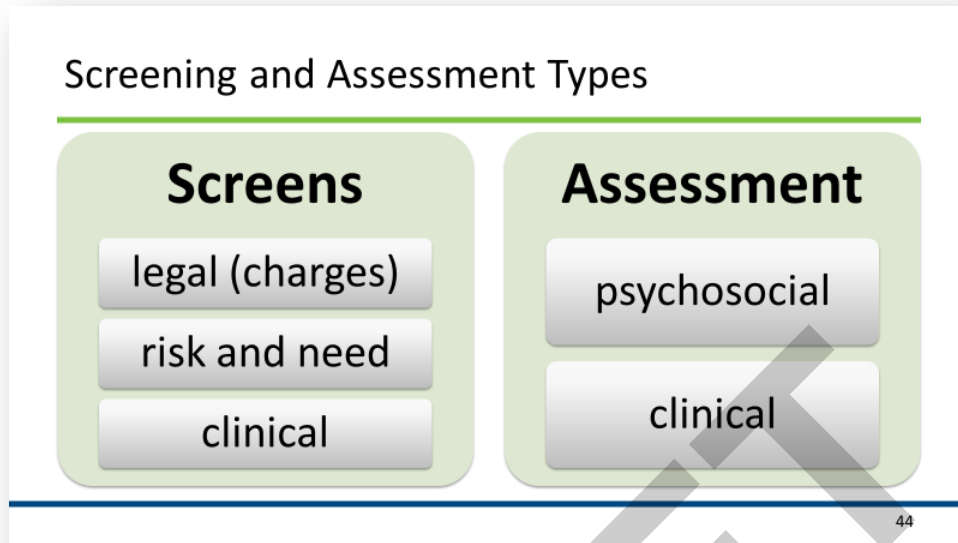
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	<p><b>Instructor:</b></p> <p>Welcome to Day 2 of VICTOR! Before we discuss risk-need-responsivity theory, let’s have a conversation about screening and assessment in general.</p> <p>As criminal justice professionals, we spend much of our time interacting with people charged with criminal offenses and brought before the courts. We often know very little, if anything, about these defendants until we start to learn about them.</p>
	<p><b>Ask:</b></p> <p><i>What</i> do we want to know about people?</p> <p><b>Anticipated Responses:</b></p> <p>Where do they live? What do they do for a living? What is their criminal background? Do they have a substance use disorder? Do they take medication? Are they a veteran? Are they likely to recidivate?</p>
	<p><b>Flipchart:</b></p> <p>Write participant responses on flipchart.</p>
	<p><b>Ask:</b></p> <p><i>Why</i> do we want to learn about people?</p> <p><b>Anticipated Responses:</b></p>

	To help us decide whether to charge a person with a crime; what charge(s) to file; whether the person should be released on bail from pretrial detention; what sentence or disposition to impose; what alternative diversion programs might be suitable for an individual; what treatment services should be administered, etc.
	<p><b>Ask:</b> How can we learn about people?</p> <p><b><i>Anticipated Responses:</i></b> By consulting records like arrest records and criminal histories; by talking to the defendant; by talking to the defendant’s family; by using screening and assessment forms and tools</p>
	<p><b>Flipchart:</b> Write participant responses on flipchart.</p>
	<p><b>Instructor:</b> All of these responses are correct. Collectively, we refer to the process of learning about defendants as “screening and assessment.” Screening and assessment can serve a wide range of functions in the criminal justice system and can take many forms.</p>

## Screening vs. Assessment

Time: 5 minutes



**Ask:**

What's the difference between screening and assessment?

**Anticipated Responses:**

Screening is typically performed prior to assessment; screening is less detailed and less precise than assessment; screening is less expensive and less resource-intensive than assessment.



**Instructor:**

The major difference between screening and assessment is that screening is used to *rule out* cases that are unlikely to have a trait or condition, and therefore do not require further evaluation or investment of resources. Cases that cannot be ruled out confidently through screening may or may not have a trait or condition requiring treatment, and therefore require more in-depth assessment. The key point here is that individuals who score high on screening tools may *not*, in fact, have a disorder or condition requiring treatment, and should *not* receive services until they have been assessed more thoroughly.

Screening may be performed by various professionals, including probation officers and pretrial officers, assuming they have the necessary training. Assessments, in contrast, usually must be performed by specially trained professionals. And some assessment tools are better administered by someone with a higher level of specialty such as a clinical license.

There are many types of screens and assessments. Not all will be appropriate in each case. Throughout VICTOR, we will discuss various types of screens and assessments, and we'll give examples. For now, we're going to delve into the theory behind a major component of criminal justice screening and assessment: risk-need-responsivity theory.

# Overview of Risk-Need-Responsivity Theory

Time: 10 minutes

## Overview of RNR Theory

Criminal Justice Term	Clinical Term	Definition
<b>Risk</b>	Prognosis	<ul style="list-style-type: none"> <li>• Likelihood of success in standard treatment, or anticipated difficulty treating the person</li> <li>• Indicates how intensively or aggressively to treat the person</li> </ul>
<b>Need</b>	Diagnosis	<ul style="list-style-type: none"> <li>• Clinical symptoms or functional impairments requiring treatment</li> <li>• Indicates what symptoms or disorders should be treated</li> </ul>
<b>Responsivity</b>	Case formulation	<ul style="list-style-type: none"> <li>• Matching services to participants' risk (prognosis) and need (diagnosis) levels</li> <li>• Indicates what services to provide, what services not to provide, and in what order or sequence to provide services</li> </ul>

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### Instructor:

The most effective criminal justice interventions are based on the principles of risk-need-responsivity theory, or RNR. In brief, risk tells us *who* we should target for our most intensive services, need tells us *what types* of services we should provide, and responsivity tells us *how* we should structure those services and in *what order or sequence* we should deliver them. It's helpful to think of these terms as analogous to the medical or clinical terms of prognosis, diagnosis, and case formulation.

Let's start by defining the term "risk." In the criminal justice context, risk refers to the likelihood of future criminality—or the that someone's behavior won't change, and they will continue to engage in crime or fail to respond to rehabilitation efforts. This is analogous to the medical concept of *prognosis*. Patients with a complicated or poor prognosis have risk factors (such as a history of smoking or high blood pressure) that make them less likely to respond to standard medical treatments; therefore, physicians tend to treat them more aggressively. Physicians may, for example, prescribe higher doses of medication, perform surgery, or use radiation or chemotherapy for patients with a poorer prognosis.

On the other hand, physicians do *not* provide intensive or aggressive treatments for patients who have a good prognosis, because they are unlikely to benefit from the extra services, and may experience unwarranted side effects. This would waste precious time and money, and may leave patients worse off.

By analogy, criminal justice professionals should treat persons with higher risk factors for recidivism more aggressively, and should treat low-risk persons less aggressively. We'll

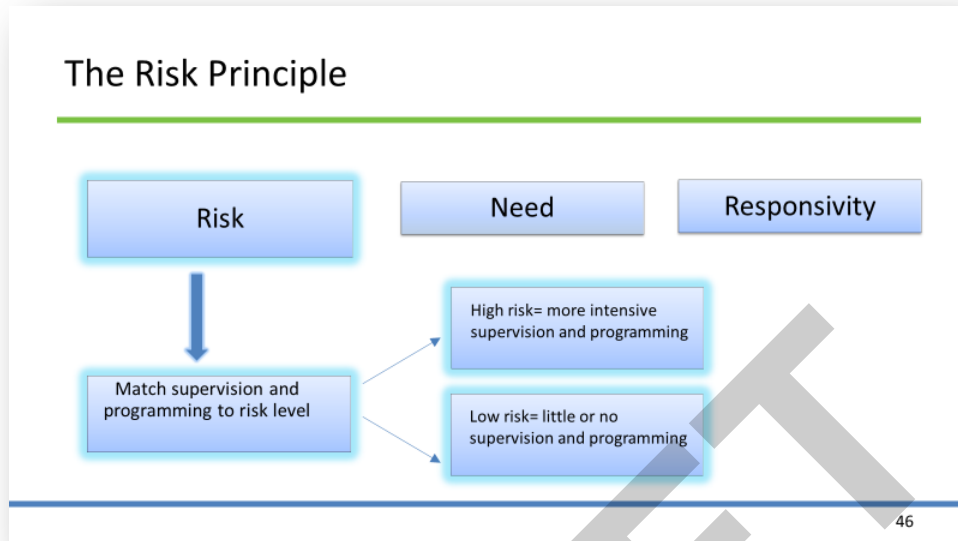
return to this later.

Now let's talk about "need." Need or *diagnosis* tells us what symptoms to treat and what types of services we should provide for those symptoms. Substance use, mental health, and medical disorders are commonly found among justice-involved veterans. The most common disorders include post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), substance use disorders, and major depression. Criminal justice programs should therefore routinely screen all military veterans for these disorders, and provide or refer them for indicated services. We'll talk more about all of this later.

And finally, we have "responsivity." Responsivity tells us how to go about developing an individualized treatment plan to target different types of individuals and their relevant needs. It tells us *what services* to provide, and just as importantly, in *what order* to provide them. Delivering services in the wrong order not only fails to improve outcomes, but can make outcomes worse by over-burdening individuals and placing unrealistic expectations on them. For example, it makes little sense to help someone find employment if they are struggling with severe PTSD from a recent traumatic event. If the PTSD severely affects functioning, it may need to be addressed first before the person can be expected to manage the stress of a full-time job.

# The Risk Principle

Time: 15 minutes



**Ask:**

What do we mean by “risk”?

**Anticipated Responses:**

Responses will vary.



**Answer Key:**

**Correct Responses:**

Having a greater likelihood of committing another offense; having a greater likelihood of committing an infraction or violation of probation

**Incorrect Responses:**

Having a long or serious criminal record; posing a threat to public safety; posing a risk of violence or dangerousness; being charged with a serious crime such as a violent felony or sex offense



**Instructor:**

Risk, in the criminal justice context, does *not* refer to the severity of the current offense, or to the likelihood of committing a serious or violent crime. Rather, risk refers to the *likelihood* or *probability* that an individual will continue to do what they did before. With justice-involved individuals, this generally means a greater likelihood of committing another offense, often a similar type of offense to what they committed in the past. So, if a person was previously arrested for drug possession, high risk typically means they have a significant

probability of being arrested again for drug possession, or for another drug-related crime.

Returning to the medical analogy, physicians often give more intensive treatment to patients who have a poor prognosis or higher risk level, because they are unlikely to get better without those additional services. Unfortunately, in the criminal justice system we often *exclude* patients with a poor prognosis from the very services they require to get better by using incarceration instead of treatment or other suitable programs. We do this because we erroneously equate risk with dangerousness, which leads us to exclude the neediest individuals from our most intensive and effective programs. Instead of jail, we should be targeting those individuals for our best programs.

I want to elaborate on the issue of dangerousness. Risk is best measured by using validated risk assessment tools. Most risk assessment tools that are used in day-to-day practice in the criminal justice system were not validated to predict the likelihood of dangerousness, violence, or serious felonies. They were validated to predict the likelihood of committing *any* type of new crime or technical probation violation. Unless a court or probation department uses a specialized instrument designed specifically for assessing dangerousness, risk should *not* be equated with a threat to public safety.



**Ask:**

What is the risk principle?

***Anticipated Responses:***

Higher risk persons need more intensive programming than lower risk persons; don't mix risk levels in programs; minimize intervention with low-risk persons






**Instructor:**

The risk principle states that risk for new criminal behavior can be predicted and that correctional interventions should focus on higher risk offenders. Returning to a medical analogy, the risk principle tells us that providing too much service can cause unnecessary side effects while achieving no greater therapeutic benefits. On the other hand, providing too little service allows the patient's disorder to continue to get worse and lessens the patient's optimism for improvement.

Staying with the medical analogy, risk can also be *contagious*. If you put high- risk and low-risk people together in a treatment group or residential program, you will often wind up with a group of high-risk people. The high-risk participants raise the risk level of the low-risk participants, but the low-risk participants have no impact whatsoever on the high-risk participants.

This would be like placing a patient with a broken leg on the tuberculosis ward of a hospital. Now he has a broken leg *and* tuberculosis.

	<p>As well, over-treating and over-supervising low-risk persons can actually increase their risk to reoffend by taking them away from their pro-social community and family influences. For example, if a low-risk person is required to report to probation every week, they might lose their job, which was a “protective” factor—one that made them less likely to recidivate.</p> <p>Note also that low risk does not mean <i>no</i> risk, so there may be some low-risk individuals who are “on the fence” and may need some assistance with what are called <i>stabilization services</i>, such as housing assistance, medical treatment, or transportation assistance. These services should be delivered in separate programs or treatment groups comprised exclusively of low-risk individuals to avoid mixing them with higher risk peers.</p>
	<p><b>Ask:</b> How do we know what an individual’s risk level is?</p> <p><b>Anticipated Responses:</b> Responses will vary.</p>
	<p><b>Answer Key:</b> <b>Correct Responses:</b> By using a validated risk assessment instrument.</p> <p><b>Incorrect Responses:</b> You can tell from their record; you can tell because you know their type</p>
	<p><b>Instructor:</b> That’s right. The best way to predict risk of recidivism is to use a validated risk instrument. Let’s take a look at which factors contribute to a person’s risk score.</p>

# The “Big Eight” Criminogenic Risk Factors

Time: 10 minutes

### The “Big Eight” Criminogenic Risk Factors

The “Big Four”	The “Moderate Four”
<ul style="list-style-type: none"><li>• Criminal History (static)</li><li>• Antisocial Personality Pattern</li><li>• Antisocial Attitudes</li><li>• Criminal peer networks</li></ul>	<ul style="list-style-type: none"><li>• Family Dysfunction</li><li>• School or Work Deficits</li><li>• Leisure Activities</li><li>• Substance Abuse</li></ul>

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## Instructor:

A robust body of scientific evidence now suggests that the likelihood of new criminal behavior can be reliably assessed based on a limited set of factors, commonly referred to as the “big eight” and then broken down into the “big four” and the “moderate four” risk factor. The slide lists the most prominent predictors of recidivism risk. Let’s discuss common ways in which each factor is measured and tends to predict risk.

**Criminal History:** Prior adult and juvenile arrests; Prior adult and juvenile convictions; Prior failures-to-appear; Other currently open cases; Prior and current charge characteristics (e.g., presence of firearms, violence, drug charges, etc.).


**Antisocial Personality Pattern:** Impulsive behavior patterns; Lack of consequential thinking.

**Antisocial Attitudes:** Patterns of antisocial thinking, which typically reflect the following primary constructs: (1) Lack of empathy; (2) Externalization of blame; (3) Entitlement; (4) Attitudes supportive of violence.

**Criminal peer networks:** Peers involved in drug use, criminal behavior and/or with a history of involvement in the justice system.

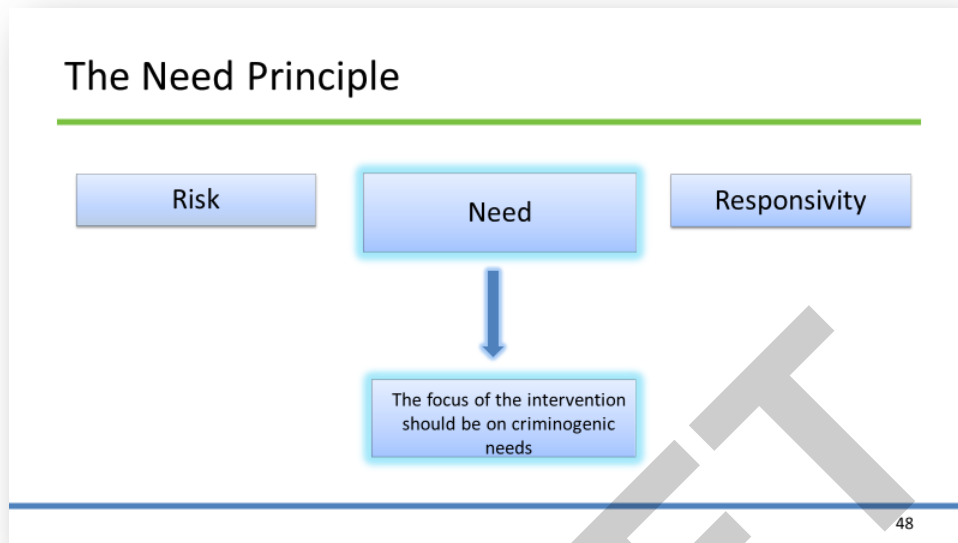
**Family Dysfunction:** Unmarried; Recent family or intimate relationship stress; Historical lack of connection with family or intimate partner.

**School or Work Deficits:** Poor past performance in work or school (lack of a high school

	<p>diploma; history of firing or suspension); Alienation from informal social control via work or</p> <p>school (e.g., chronic unemployment).</p> <p>Leisure Activities: Isolation from pro-social peers or activities.</p> <p>Substance Abuse: Duration, frequency and mode of current substance use; History of substance abuse or addiction; Self-reported drug problems.</p>
	<p><b>Instructor:</b></p> <p>There are two other factors that are generally considered to be strong predictors of criminal risk but are typically not included in the big eight: <i>demographics</i>—younger age is a predictor of risk, as is male gender, and <i>residential instability</i>—homelessness and frequent changes of address are contributors to risk.</p>

## The Need Principle

Time: 10 minutes



**Ask:**

What is the need principle?

**Anticipated Response:**

It tells where to focus our treatment; it helps us understand which needs can be impacted by our intervention



**Instructor:**

To answer this question, we need to talk about risk again for a moment. Broadly speaking, there are two types of risk factors that predict criminal recidivism – those that are *static* or *unchangeable*, and those that are *dynamic* or *changeable*. An example of a static risk factor is a person's age at the time of his or her first arrest. We know through research that when a person begins to commit crime at a young age, the likelihood that he or she will continue this behavior is significantly increased. However, we cannot go back in time and change when a person first began to commit crimes, so this risk factor cannot be a target of treatment or intervention.

Dynamic risk factors are those that we *can* target for change. For example, hanging out with people who commit crimes or use drugs significantly increases the likelihood that a person will recidivate. This is something we can change, and therefore we can reduce the risk of recidivism. Researchers call these dynamic risk factors *criminogenic needs*.

The need principle states that therapeutic interventions should be directed towards an individual's "criminogenic" needs—those dynamic needs that can be statistically tied to

recidivism.

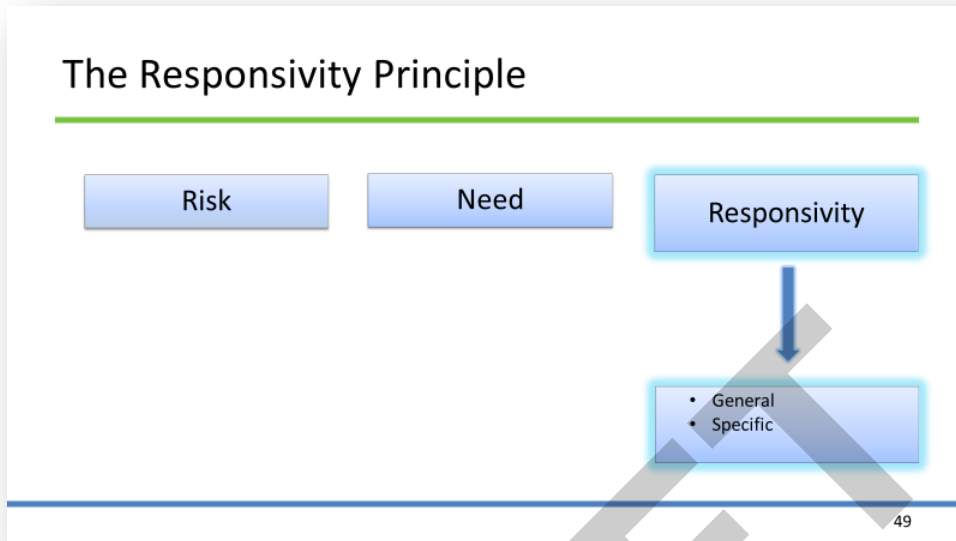
Justice-involved individuals often have several needs and/or problems in their lives. Bear in mind, however, that not all of these needs are criminogenic, meaning they may not be the *cause* of their crimes. Many problems in offenders' lives are the *result* of their crimes rather than the *cause* of their crimes. For example, it is often assumed that individuals commit crimes because they are unemployed. However, many justice-involved individuals are unemployed because they commit crimes, or because they are suffering from a mental health or substance use disorder. It is difficult to obtain employment if a person has a criminal record; it is also difficult to maintain employment if a person is experiencing severe mental health afflictions such as PTSD.

Unemployment or illiteracy are sometimes referred to as *maintenance needs*, because if they are not addressed, participants are likely to regress over time and lose the gains they achieved in treatment. Improvements in certain maintenance needs, such as educational achievements or job skills, predict better long-term persistence of treatment effects after a person is no longer involved with the criminal justice system.

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# The Responsivity Principle

Time: 10 minutes



**Ask:**

The third principle is the responsivity principle. Can anyone explain the responsivity principle to the group?

**Anticipated Response:**

Interventions should be evidence-based, and should be tailored to individuals' level of motivation, learning style, personality traits, and life circumstances to maximize learning.



**Instructor:**

Correct. The responsivity principle states that treatment should be adapted to the specific risk factors, needs, strengths, and other attributes of the individual.

Matching evidence-based interventions to participants' learning styles and levels of motivation is referred to as *general responsivity*. For example, when case managers or program staff are developing a case plan, or determining how best to respond to a program participant, interventions that are best suited for justice-involved populations are typically:

- behavioral or cognitive-behavioral in orientation, as opposed to being psychodynamic or insight-oriented
- teach participants to think before they act, and encourage them to consider the potential consequences of their actions before engaging in those actions
- employ motivational-enhancement techniques to increase participants' intrinsic desires and readiness for change

- model appropriate pro-social behaviors
- reward achievement of treatment goals
- express verbal disapproval of antisocial behaviors
- apply swift, certain, and gradually escalating sanctions for infractions

There is a second type of responsivity called *specific responsivity*. Specific responsivity refers to barriers or conditions that impact an individual's response to correctional rehabilitation services. Examples of common specific-responsivity factors include a person's gender, age, ethnicity, language fluency, emotional maturity, cognitive ability, intellectual development, educational attainment, and mental health status.

Among other things, specific responsivity requires us to match participants to services and programs based on their risk and need profiles, and deliver services in an appropriate sequence to achieve optimum results and avoid over-burdening the individual. It is analogous to the medical concept of *case formulation* or *treatment-planning*.

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# Predicting Recidivism: Clinical vs. Actuarial Decision Making

Time: 25 minutes

## Two Approaches to Predicting Recidivism: Clinical v. Actuarial

- 1) Reliance on **clinical** “expertise” and intuition
  - Practitioners tend to have strong belief in the value of their own experience.
- 2) Use of **actuarial** decision-making tools.
  - Standardized screening and assessment tools to make evidence-based decisions about treatment, sentencing, and/or case planning

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### Instructor:

Now we'll talk about something that you might hear lots about at work: actuarial decision-making. We'll talk about screening and assessment in general shortly, but for now, we're going to focus mostly on screening and assessment for risk of recidivism, which is typically done using clinical judgement or actuarial tools, or a combination of both. As we'll see in a minute, one method tends to be more accurate than the other.



### Ask:

What do we mean by actuarial decision-making?







### **Anticipated Responses:**

Using scientifically validated screening and assessment tools; making decisions based on research and evidence; using proprietary instruments



### Instructor:

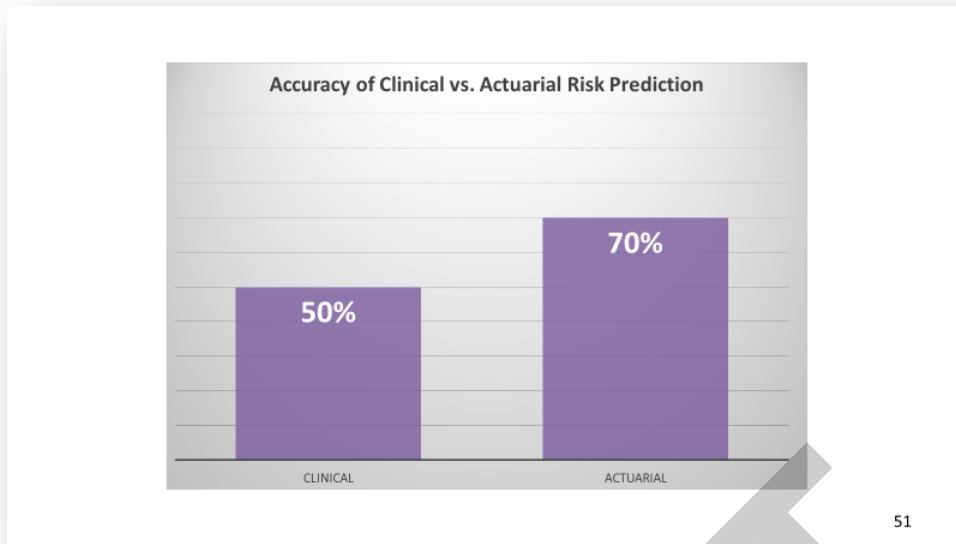
That's right. In the criminal justice field, actuarial decision-making involves using standardized screening and assessment tools to make decisions about treatment, sentencing, and/or case planning. Actuarial tools contain items or variables that have been validated through research studies to predict criminal recidivism, failure in treatment, or other relevant outcomes, such as drug test results or employment. You may also hear these types of tools be referred to as “scientific tools,” “validated instruments,” “evidence-based tools,” “standardized instruments,” or any combination of those words.

	<p><b>Ask:</b> What is the “opposite” of actuarial decision making?</p> <p><b>Anticipated Responses:</b> Using your own judgement; clinical judgement</p>
	<p><b>Instructor:</b> In contrast to actuarial decision-making, clinical or professional decision-making relies on the experience, skills, and intuition of professionals, such as judges, prosecutors, or treatment providers, to make treatment recommendations, predict recidivism, or make decisions about placement in special programming, such as a veterans treatment court. Social science often confirms what justice practitioners already know. For example, many prosecutors intuitively understand the importance of criminal history in predicting future offending. In other cases, however, science contradicts common assumptions. For instance, validation research in the criminal justice field has consistently shown that the presence of a diagnosis for mental illness is not a significant factor in predicting future criminal behavior, contrary to long-held assumptions in the field. Empirical research also challenges the use of current offense severity as a proxy for risk of future crime. Put simply, a felony defendant is not more likely to be re-arrested than a misdemeanor. On balance, actuarial—or data-driven— risk models have tended to outperform the judgments of individual practitioners, including clinical professionals, in accurately assessing risk.</p>
	<p><b>Ask:</b> Which is more accurate when it comes to predicting risk of recidivism, actuarial decision-making or professional judgment?</p> <p><b>Anticipated Responses:</b> Actuarial decision-making is more accurate; clinical decision-making is more accurate</p>
	<p><b>Instructor note:</b> Many participants are likely to be aware that actuarial decision-making is more accurate than professional judgment in predicting reoffending; however, they probably do not know how much more accurate it is.</p>
	<p><b>Instructor:</b> In fact, standardized risk assessment tools are superior to professional judgment in assessing risk of recidivism and predicting outcomes in correctional rehabilitation programs. Several meta-analyses have determined that professional judgment is often little better than chance in predicting outcomes.</p>
	<p><b>Ask:</b> How often do you think professional judgment correctly predicts criminal justice outcomes? 20% percent of the time? 80% of the time? What about risk assessment tools?</p>

***Anticipated Responses:***

Responses will vary.

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**Instructor:**

On average, criminal justice and treatment professionals accurately predict criminal justice outcomes around 50% of the time, which is about the same as flipping a coin. In contrast, standardized risk assessment tools predict recidivism with approximately 70% accuracy. Thus, the rationale behind expanding the use of formal risk assessment tools is that they offer the potential for helping justice agencies make more informed decisions. For this reason, best practices is to use validated risk and need assessment tools whenever making decisions about program eligibility, supervision planning, and level-of-care placements. To emphasize this point, research in the field of treatment courts has shown that programs that employ actuarial risk and need assessment tools have been found to be 50% to 100% more effective and more cost-effective, on average, than programs that rely on professional judgment or non-validated procedures to make treatment and placement decisions.

Actuarial tools are not perfect, and indeed are wrong about a third of the time on average. Professionals should, therefore, be prepared to take other relevant factors into consideration that are not included in the assessment tools, such as information received from friends or family members, and should override assessment results when there is a convincing and articulable reason for doing so.

Keep in mind that criminal justice professionals should never turn their decision-making authority over to actuarial tools. They have an important responsibility to exercise independent discretion when making decisions that affect individuals' legal rights, personal liberty, and/or emotional welfare.

The take-home message is that criminal justice professionals should *carefully consider* assessment results when making critical decisions, and should not rely exclusively on their

	intuition or personal predilections, which are often wrong.
	<p><b>Ask:</b></p> <p>Does using actuarial assessment tools increase the likelihood that individuals will be denied bail, imprisoned, or denied treatment?</p> <p><b>Anticipated Responses:</b></p> <p>Responses will vary.</p>
	<p><b>Instructor Note:</b></p> <p>This question will likely generate an interesting and potentially heated discussion.</p>
	<p><b>Instructor:</b></p> <p>There has not been a good deal of research on this question. However, virtually all studies that have been conducted thus far have found that using standardized risk and need assessment tools <i>reduced</i> the use of incarceration or detention, and increased diversion to treatment and rehabilitation programs.</p>
	<p><b>Ask:</b></p> <p>Does using actuarial assessment tools increase racial, ethnic, or gender disparities in the criminal justice system?</p> <p><b>Anticipated Responses:</b></p> <p>Responses will vary.</p>
	<p><b>Instructor Note:</b></p> <p>This question, too, is likely to generate considerable controversy.</p>
	<p><b>Instructor:</b></p> <p>Again, there has not been sufficient research in this area. Although a small number of studies have reported disparate racial and ethnic impacts from a few assessment tools, most studies have found that using standardized risk and need tools <i>reduced</i> incarceration and detention rates and access to treatment services.</p> <p>Assuming researchers have carefully examined the validity of a tool to ensure it is equally predictive of outcomes for racial and ethnic minorities and women, use of that tool is likely to reduce rather than exacerbate unfair disparities.</p>

## Examples of Actuarial Risk Assessment Instruments

Time: 10 minutes



**Ask:**

What are some common examples of risk assessment instruments?

**Anticipated Responses:**

- Level of Service Inventory—Revised (LSI-R)
- Level of Service Case Management Inventory (LS/CMI)
- Correctional Offender Management Profiling for Alternative Sanctions (COMPAS)
- Ohio Risk Assessment System (ORAS)
- Federal Post Conviction Risk Assessment (PCRA)
- Risk Prediction Index (RPI)
- Risk and Needs Triage (RANT)
- Static Risk Tool
- Wisconsin Risk and Need Assessment Scale (WRN)



**Instructor:**



Correct. These tools were developed to predict *general* criminal recidivism among adult justice-involved persons. They were not designed specifically to predict violence or dangerousness.



**Ask:**

What are some examples of risk assessment instruments that are designed to predict violence or dangerousness?

**Anticipated Responses:**

	<ul style="list-style-type: none"><li>• Historical, Clinical, Risk Assessment-20 (HCR-20)</li><li>• Psychopathy Checklist- Revised (PCL-R)</li><li>• Static-99</li><li>• Spousal Assault Risk Assessment (SARA)</li><li>• Sexual Violence Risk-20 (SVR-20)</li></ul>
	<b>Instructor Note:</b> Read any responses that aren't said out loud by participants.
	<b>Instructor:</b> Correct. These tools were developed specifically to predict violence or dangerousness, such as sex offenses, domestic violence, or assault. You can find a list of the most common general and violence risk prediction tools in your Participant Manual on page 64.

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## Break

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## Lesson 2: Risk Assessment for Veterans

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### Lesson Preview:

Although the principles of risk assessment for the general population apply to veterans, there is some research that suggests that additional factors prevalent in the veterans population may play a role in predicting risk. This lesson begins with a discussion of those factors and then goes on to describe one effort by the National Institute of Corrections to create a set of screening, assessment, and case planning tools designed specifically for the veterans population. Another case planning tool—the Quadrant Model—will be discussed, and participants will have an opportunity to apply the knowledge they gain through a case planning exercise.

### Topics:

- Additional Risk Factors for Veterans (5 minutes)
- The *Veterans Treatment Court Enhancement Initiative* (25 minutes)
- The Quadrant Model (15 minutes)
- Activity: Quadrant Model Case Vignettes (45 minutes)

**Total Instruction Time:** 1 hour, 30 minutes

## Additional Risk Factors for Veterans

Time: 5 minutes

### Additional Risk Factors for Veterans

- Traumatic brain injury (TBI) – especially when combined with irritability or hostility
- Post-traumatic stress disorder (PTSD) – especially when combined with hostility, prior combat exposure, or substance abuse
- Homelessness when combined with PTSD, TBI, or substance misuse

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#### Instructor:

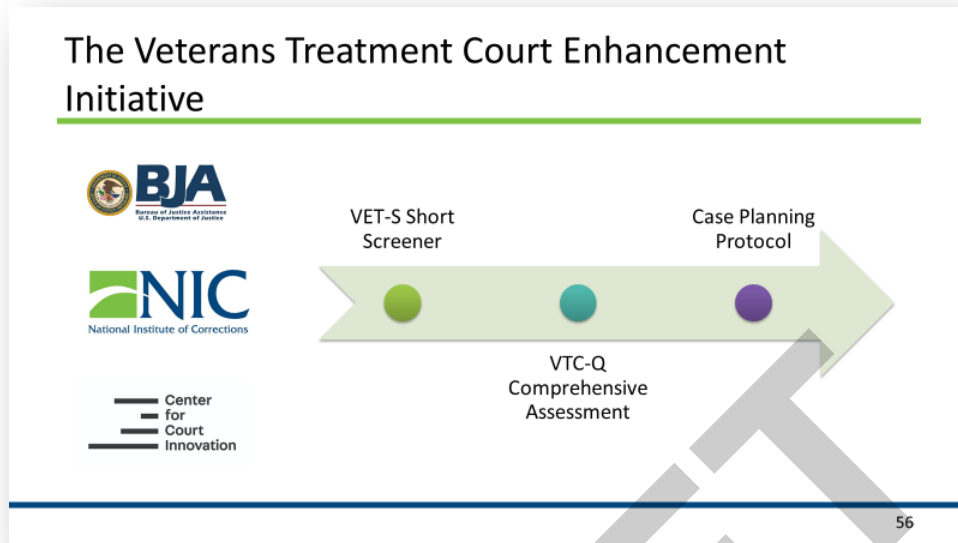
We've mentioned several validated risk-need assessment tools that are commonly used in the criminal justice field. Despite decades of research about risk and need assessment, few studies have examined the validity of these risk tools among veterans or active-duty military personnel. Studies do indicate that many of the same risk factors that predict general recidivism or violent recidivism in other justice-involved populations also predict recidivism among veterans, such as younger age, early onset of delinquency or substance use, and alcohol or drug abuse. However, additional risk factors have also been identified among veterans that are highly predictive of recidivism, and should therefore also be assessed:

- Traumatic brain injury (TBI) – especially when combined with irritability or hostility
- Post-traumatic stress disorder (PTSD) – especially when combined with hostility, prior combat exposure, or substance abuse
- Homelessness when combined with PTSD, TBI, or substance misuse

An instrument called the *Violence Screening and Assessment of Needs for Veterans* (VIO-SCAN) includes these additional risk factors to assess risk of violence among military veterans.

## The Veterans Treatment Court Enhancement Initiative

Time: 20 minutes



### Instructor:

In order to learn more about how all of these factors affect risk assessment in veterans, the Center for Court Innovation in New York led the effort test to develop and test evidence-based tools to screen and assess veterans and match them to effective levels of criminal justice supervision, treatment for substance use and mental health disorders, and other services necessary to facilitate successful readjustment to civilian life. The Bureau of Justice Assistance and the National Institute of Corrections are funding this effort. The three tools that the Center created are the VET-S Short Screener, the VTC-Q Comprehensive Assessment, and the Case Planning Protocol. The tools are currently being pilot tested in VTCs in Seattle, Tampa, and Billings, Montana. As soon as these tools have been sufficiently studied, they will be made available to the field. Let's take a deeper look at these tools.

## VET-S Need Flags

- Potentially eligible for VHA benefits
- Combat
- Multiple DUI/DWI convictions
- IPV - batterer
- History of violent offenses
- Education
- Employment
- Housing
- Substance use - alcohol
- Substance use – drugs
- Criminal thinking
- Social isolation
- Prior mental health hospitalization
- Psychosis
- PTSD
- Current withdrawal symptoms
- Suicidal ideation

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### **Instructor Note:**

Note that the information on this slide references key aspects of the VET-S Short Screener.



### **Instructor:**

The short screener, or VET-S, is a quick pre-adjudication screening tool that allows jurisdictions to identify veterans and active-duty military personnel as early as possible and to get a snapshot of their risk and need profile. With this information, pre-trial agencies, courts, and attorneys can make informed decisions about case processing for each person—such as whether to refer a case to a veterans

treatment court. The VET-S contains about 50 questions, takes approximately 15 minutes to administer, and can be scored by hand. The first section—the criminal history review—does not involve an interview, and can be completely using available records. The VET-S produces a result of very high, high, moderate, or low risk, as well as several needs flags, listed on this slide.

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## VTC-Q Risk Assessment Domains



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### Instructor Note:

Note that the information on this slide references key aspects of the VET-Q Comprehensive Assessment.



### Instructor:

The comprehensive assessment, or VTC-Q, allows veterans treatment court staff or other court system practitioners to learn more about an individuals' needs and criminogenic risk factors and to create effective supervision and case management plans tailored to each veteran's profile. The VTC-Q is much more robust than the short screener—it contains about 160 questions and can take more than an hour to administer. The assessment is broken into three main sections: the criminal record review, the risk assessment, and the needs assessment. Both the risk and the needs assessment require a defendant interview. Risk-related question domains include criminal history, employment, education, housing, social environment, impulsivity, anger, attitudes, and substance abuse. A veteran's answers to most of these questions will receive a score and be factored into the final risk level. Many of the answers will contribute to the needs flags as well. The needs assessment probes for several other domains: mental health, lifetime trauma experiences, recent trauma symptoms, and intimate relationships. A veteran's answers to these questions do *not* contribute to the risk score. The needs assessment portion includes validated screening tools for TBI and PTSD—we'll talk about why that's so important in the next module.

Both tools include questions about military background. Some of the questions from the comprehensive assessment are:

- In what branch(es) of the Armed Forces did you serve?
- Is/was your spouse/partner also a member of the Armed Forces/National Guard/Reserves?

- What is your current military status?
- What is/was your military rank?
- What is/was your job in the military?
- Altogether, how much time have you served on active, reserve, or National Guard duty?
- How many times were you deployed?
- When was your last deployment?
- Have you ever been deployed to a combat zone?
- Have you ever gotten in trouble for breaking the rules while you were in the military?

The Comprehensive Assessment also produces a result of very high, high, moderate, or low risk, and flags for the same needs as the Short Screener.

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## Case Planning Protocol

Risk Level	RNR Supervision Level
Minimal Risk (0-19)	Court 1x week for four weeks, every other week for next month, monthly thereafter Probation (in person) weekly for first two months then twice a month for next two months, then monthly thereafter (preferably in court on the same date as court appearance) Drug testing & SCRAM as indicated 9-12 month term of participation
Low Risk (20-39)	Court 1x week for four weeks, every other week for next month, monthly thereafter Probation (in person) weekly for first two months then twice a month for next two months, then monthly thereafter (preferably in court on the same date as court appearance) Drug testing & SCRAM as indicated 12-15 month term of participation
Moderate Risk (40-59)	Court 1x week for three months, every other week for next month, monthly thereafter Probation (in person) weekly for first 3-4 months, then less frequently as indicated Drug testing & SCRAM as indicated 15-18 months term of participation
High Risk (60+)	Court 1x week for four months, every other week for next month, monthly thereafter Probation (in person) weekly for first 6 months, then less frequently as indicated Drug testing & SCRAM as indicated



### Instructor Note:

Note that the information on this slide references key aspects of the Case Planning Protocol. Give participants a few minutes to look over this slide, which is also in their Participant Manual on page 18 and to ask any questions.



### Instructor:

The third tool in the set of instruments is the Case Planning Protocol. The Case Planning Protocol is a supervision grid designed to help VTC teams apply the results of the comprehensive assessment via evidence-informed supervision decisions. The purpose of the grid

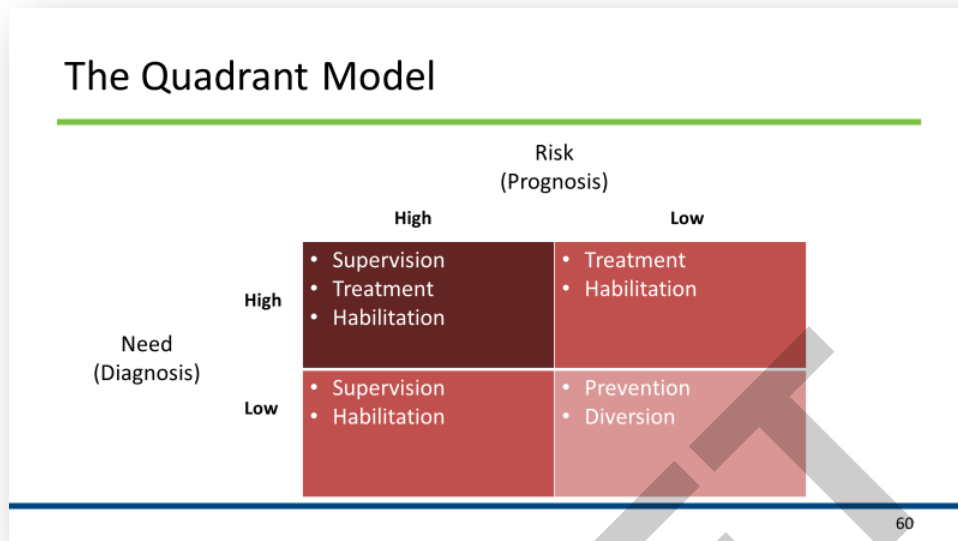
is to ensure that teams are following the “responsivity” principle of risk-need-responsivity theory, by matching the level of intervention to each person’s risk level. Interventions such as court appearances, probation appointment, drug testing and mandate lengths are typically included in the case planning protocol. For example, the grid might recommend that a high-risk veteran comes to court weekly, but that a low-risk veteran only needs to come to court every other month.

The protocol is customized for each jurisdiction, taking into account local practices and resources. During the initial pilot phase, Center for Court Innovation staff assisted each jurisdiction in creating their customized protocol. On the slide, you can see a sample protocol from one of the courts.

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# The Quadrant Model

Time: 15 minutes



## Instructor:

Let's take a look at another grid model which can be useful *before* someone gets to a veterans treatment court. The principles of RNR to help us make better decisions about case planning for justice-involved veterans, including whether someone is eligible for diversion programs or other court- or community-based treatment options.

The *Risk/Need Quadrant Model* is a conceptual framework for case planning that borrows heavily from medical decision-making. The Quadrant Model crosses two levels of risk (high and low) with two levels of need (high and low), yielding four profiles—or quadrants—that have important implications for selecting effective correctional dispositions and behavioral care plans for justice-involved persons. Broadly speaking, there are three general practice recommendations: supervision, treatment, or habilitation. Each quadrant will prescribe a combination of these three.

Supervision refers to sessions with a probation officer or other criminal justice professional, probation field visits to the participant's home or place of employment, regular court appearances in front of the judge, periodic drug and alcohol testing, and/or swift and certain rewards for achievements and sanctions for infractions.

Treatment typically includes substance use disorder treatment, mental health treatment, or other social services delivered by a licensed or certified clinical professional.

Habilitation refers to interventions that encourage participants to think before they act, and teach them productive strategies for resolving interpersonal conflicts and other problems

without recourse to illegal activity or substance use. Evidence-based examples of such programs include Thinking for a Change, Moral Reconation Therapy (MRT), and Reasoning & Rehabilitation (R&R). Habilitation also includes services that help with employment, education, and other needs. Examples may include job training, life-skills training, or parenting classes.

Persons in the upper left quadrant who are high risk and high need typically have a serious diagnosis such as addiction or mental illness, and also have a complicated prognosis due to such factors as antisocial attitudes, criminal peer groups, or extensive criminal histories. These individuals typically require a combination of all three service elements. The treatment system and criminal justice system need to work together to share information about these individuals, co-manage their cases, and coordinate the provision of a range of indicated services. Veterans treatment courts (VTCs) are one example of a program that utilizes a multidisciplinary team of professionals to deliver an integrated curriculum of supervision, treatment, and habilitation services for justice-involved veterans.

Persons in the upper right quadrant who are low risk and high need typically require an emphasis on treatment and habilitation services, but they usually do not require intensive monitoring by the criminal justice system. In fact, they may get worse if they are required to interact frequently with high-risk peers in court or probation sessions. Case managers or court personnel should identify these types of veterans as soon as possible after they enter the justice system, make swift referrals to the VA and other indicated veterans services, and monitor their compliance in treatment. We talked about strategies for early identification of veterans in the previous module.

Persons in the lower left quadrant who are high risk and low need typically require intensive supervision and habilitation services, but do not require substance use or mental health treatment. Providing treatment for these individuals would be a waste of resources and may needlessly disrupt the treatment program. These individuals may be well-suited for traditional probation programs, which focus on monitoring compliance with probation conditions, rewarding productive achievements and sanctioning violations, and delivering cognitive-behavioral interventions designed to address criminal-thinking patterns and enhance engagement in productive, pro-social behaviors.

Finally, low risk and low need participants typically do not require any of these services. These individuals will often be best suited for low-intensity prevention services, such as brief psycho-educational groups, and should ideally be diverted from further contact with the criminal justice system at the earliest suitable stage in the proceedings.



**Ask:**

What do we do about individuals who are classified as “moderate risk”?



**Instructor:**

Many risk and need assessment tools may categorize as much as two-thirds of test-takers as *moderate risk* or *medium risk*. According to the Quadrant Model, such individuals are categorized as either *high-risk, low-need* or *low-risk, high-need*. In other words, this model distinguishes between two different types of moderate risk, leading to different treatment and supervision recommendations.

Other case planning models, like the Center for Court Innovation's Case Planning Protocol tool that we just discussed, include more risk levels. This can be particularly useful when customized for individual jurisdictions as specific examples of supervision gradation (such as frequency of probation appointments or court appearances) can be entered into the chart.

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## Activity: Quadrant Model Case Vignettes

Time: 45 minutes

### Activity: Case Vignettes

- Which risk/need quadrant does this person appear to fall into?
- What risk factors and need factors led you to this conclusion?
- What services, if any, should this person receive?
- What services, if any, should this person not receive?

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#### Instructor:

Turn to page 19 of your Participant Manual and review the case vignettes. Then find a partner or small group and respond to the questions on the PowerPoint slide. These questions should be used to guide and inform case planning. You will have the opportunity to share your responses afterward in a large group discussion.

Please bear in mind that in actual practice, you should *not* reach conclusions about cases before first conducting a formal risk and need assessment. As we discussed, individual professional judgment is far less accurate than using validated actuarial assessment tools.

The purpose of this exercise is to encourage you to think about different profiles of justice-involved veterans you are likely to encounter, and why they should be treated differently based on their divergent needs and risk profiles.






#### Instructor Note:

You might want to structure how participants are paired, for example, by drawing numbers randomly. Participants will usually pair up with a co-worker with whom they feel comfortable. This does not give them diverse exposure to others' strengths, styles, and skills.



#### Instructor Note:

*You can decide to facilitate a whole group discussion after each vignette, or after participants have finished answering all questions for all four vignettes.*

	<ul style="list-style-type: none"> <li>• Individual reading time: 10 minutes</li> <li>• Small group discussion: 15 minutes</li> <li>• Large group discussion: 20 minutes</li> </ul>
	<p><b>Ask:</b></p> <p>For each vignette:</p> <ul style="list-style-type: none"> <li>• Which risk/need quadrant does this person appear to fall into?</li> <li>• What risk factors and need factors led you to this conclusion?</li> <li>• What services, if any, should this person receive?</li> <li>• What services, if any, should this person <i>not</i> receive?</li> </ul>
	<p><b><u>VIGNETTE 1</u></b></p> <p>George Smith is a 20-year-old who joined the army after earning a two-year Associate's Degree in accounting from a local community college. While serving at an army base in Iraq, he stepped on a concealed improvised explosive device (IED) and lost his right leg below the knee, suffered permanent injury to his right eye and severe head trauma. Edema (pressured swelling) in the left temporal lobe of his brain eventually subsided, but he continues to experience migraine headaches accompanied by diffuse anxiety, heart palpitations, nausea, and brief intervals of memory loss. He received an honorable discharge with a Purple Heart for his injuries sustained during combat.</p> <p>After leaving the army, George reportedly began self-medicating with alcohol and illegally-obtained hydrocodone, a prescription opioid commonly used for pain that can be highly addictive. He was arrested for misdemeanor illicit possession of a controlled substance (hydrocodone pills). Given the large number of pills—400 capsules—in his possession, he was also charged with possession with intent to distribute a controlled substance, felony. He has no prior criminal record and no previous involvement in mental health or substance use treatment.</p>
	<p><b>Answer Key:</b></p> <p><i>George is likely low risk and high need.</i></p> <p>Risk factors appear to be largely absent: late onset drug use, no prior treatment, no criminal record, no indication of antisocial personality traits or delinquent peer groups.</p> <p>Need factors include symptoms of TBI, coupled with likely opioid dependence and alcohol dependence or abuse.</p> <p>George should receive referral for mental health and substance use treatment, with criminal justice system monitoring and enforcing compliance in treatment.</p> <p>Many veterans treatment courts specifically target cases such as this, in which a veteran's criminal involvement is fueled primarily by a severe mental health or substance use disorder, he or she received an honorable discharge, and the injuries were directly related to a</p>

deployment to a combat zone.

Although research has not addressed this issue squarely in the context of a VTC, evidence from drug courts suggests that such individuals, who are low risk and high need, do *not* require the full range of services embodied in the problem-solving court or treatment court model. A simple referral for effective and evidence-based treatment is likely to be sufficient to forestall future criminal offending. These individuals could be harmed by being required to attend frequent court hearings or probation sessions in a VTC, where they may spend considerable time interacting with high-risk peers.



### **VIGNETTE 2:**

John Jones is a 19-year-old who enlisted in the Marine Corps as soon as he turned 18. His father insisted that he join the Marines or he would be kicked out of his home and forced to live on his own. John has a juvenile record including four arrests for possession of alcohol by a minor, public intoxication, vandalism of a school gymnasium, and assault involving a fight with a peer at school. John has been truant frequently from school beginning in the middle of the 8th grade, and he was held back in the 10<sup>th</sup> grade. He began using marijuana on a weekly, and then a daily, basis at age 15, and began using cocaine and amphetamines daily starting when he was 17. He has been in residential addiction treatment three times, each time running away or signing himself out against medical advice.

John continued to have problems in the Marines. He was constantly getting into fights with his peers and being insubordinate to his superior officers. He received a General Discharge (under honorable conditions) because of his inability to adjust to military life. He returned home, soon got into an argument with his father, and was arrested for creating a domestic disturbance while in possession of a controlled substance (methamphetamines).



### **Answer Key:**

*John is likely high risk and high need.*

Risk factors include early onset drug use, multiple prior arrests, early onset delinquency, prior treatment failures, chronic truancy.

Need factors include apparent symptoms of drug dependence.

John requires both substance use treatment and intensive monitoring by criminal justice authorities. If he is simply referred to treatment, he is unlikely to go or to stay long enough to achieve therapeutic benefits.

Some VTCs exclude persons such as John from eligibility for the program because the onset of his criminal behavior preceded his military service, his injury or illness (addiction) is not service-related or combat-related, and he received an other-than-honorable discharge.

However, the problem-solving court model is ideally suited for persons who are both high risk and high need, and whose criminal activity and behavioral disorder emerge concurrently as part of an early-onset antisocial personality syndrome. Because many VTCs will not accept persons such as John into their programs because of his poor military service record, he should be treated in a traditional drug court or comparable court-based program that merges substance use treatment with close monitoring and strict behavioral accountability. Referring John for treatment without providing careful monitoring and behavioral contingencies (rewards and sanctions) is unlikely to be effective, might endanger public safety, and is apt to waste treatment resources.



### **VIGNETTE 3**

Janet Brown spent four years in the Coast Guard. After she was honorably discharged, she began attending college on the GI Bill. In her junior year, she was arrested after a frat party for driving under the influence (DUI) of alcohol and marijuana. Because she had a prior alcohol-related incident during her freshman year involving public intoxication and creating a public disturbance (also at a frat party), she was not eligible for the jurisdiction's pretrial diversion program.



### **Answer Key:**

*Probably low risk and low need.*

Risk factors appear to be largely absent: late onset alcohol use, no prior treatment, no criminal record, no indication of antisocial personality traits or delinquent peer groups.

Need factors appear to be largely absent: no evidence of addiction or mental illness. Two alcohol-related events were separated by two years. Should be assessed formally to confidently rule out an addiction or related disorder.

There appears to be no evidence that she requires substance use treatment, mental health treatment, or intensive monitoring by criminal justice authorities. Psycho-educational groups (restricted to low risk and low need participants) should focus on driver's education, victim impacts of DUI, and alcohol health education. Janet should perhaps be placed on academic probation contingent on remaining alcohol and drug-free, and required to avoid fraternity and sorority events.



### **VIGNETTE 4**

Harry Spencer was a troubled teenager who frequently got into scrapes with the law, but was usually bailed out by his wealthy parents and their high-priced lawyers. He was arrested several times in his mid-teens for vandalism, public nuisance, and petty theft. In each instance, his lawyers managed to get the charges dropped or reduced to a juvenile status offense, including minor in possession of alcohol or noncriminal trespass. Recently, at age

18, he was arrested for breaking and entering (B&E) a business after hours when no one was present, and two days later for B&E of a home during the afternoon, again when no one was present. Worried that his criminal activity was escalating and could lead to a robbery or assault charge, his parents arranged for him to join the Army Reserves and spend long weekends and other extended periods away from their township.

After three loud arguments and physical altercations with fellow reservists and one altercation with a junior officer, he received an other-than-honorable discharge. He has no history of alcohol, drug, or mental health treatment, although he does acknowledge occasional non-compulsive use of alcohol, marijuana, cocaine, and “downers,” which he uses to relax when he gets angry and tense.



**Answer Key:**

*Harry appears to be high risk and low need.*

Risk factors include his early onset delinquency, physical assaults, multiple prior arrests, low frustration tolerance, and ability to become easily angered.

Need factors appear to be largely absent: no evidence of addiction or severe mental illness (although possibly a personality disorder). Harry does, however, appear to have pro-criminal attitudes and values.

Harry is likely to require intensive probation supervision coupled with swift, certain, and escalating rewards for achievements and sanctions for infractions. Will also require habilitation services aimed at addressing criminal-thinking patterns and enhancing his engagement in pro-social behaviors.



**Instructor:**

We have just about reached the end of the module. Before moving on, you will take a short quiz to assess your understanding of the risk, need, and responsivity principles discussed in Module 2.

## Module 2 Quiz

**Time: 15 minutes**

**Directions:** Each statement in Column A describes one principle of risk-need-responsivity theory. To the right of each statement, circle the RNR principle in Column B that best describes the statement. Each response in Column B may be used once, more than once, or not at all.

Column A	Column B		
Cognitive-behavioral therapies are the most effective form of intervention for justice-involved populations.	Risk	Need	Responsivity (general)
Justice system personnel should match the level of service to the offender's potential to re-offend.	Risk	Need	Responsivity
Use cognitive behavioral interventions that consider strengths, learning style, personality, motivation, and bio-social (e.g., gender, race) characteristics of the individual.	Risk	Need	Responsivity (specific)
Assess the dynamic risk factors that are highly correlated with criminal conduct, and target them in treatment.	Risk	Need	Responsivity
Offender recidivism can be reduced if the level of treatment services provided to the offender is proportional to the offender's risk to re-offend.	Risk	Need	Responsivity
High risk offenders need to be placed in programs that provide more intensive treatment and services while low-risk offenders should receive minimal or even no intervention.	Risk	Need	Responsivity
Effective treatment should not focus on addressing non-criminogenic needs, because changes in non-criminogenic needs are not associated with reduced recidivism.	Risk	Need	Responsivity



**Instructor:**

Now, let's take a short quiz and see how much of this knowledge we have retained. You'll have 10 minutes to complete the quiz and then we will review the answers.



**Instructor Note:**

Ask participants to open their Participant Manual to the Module 2 Quiz.

Allow them 10 minutes to complete the quiz.



**Answer Key:**

Take 5 minutes to review the correct answers with the group (see answer key above).

## Lunch Break



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# Module 3: Mental Health and Substance Use

**Time: 4 hours, 10 minutes**

## Module Overview

Module 3 informs participants about mental health and substance use disorder diagnoses and treatment for the justice-involved veteran population. Lesson 1: Mental Health draws participants' attention to unique aspects of military trauma before giving participants an overview of mental health issues prevalent in justice-involved veterans. Mental health symptomology, diagnostic criteria, and related treatment approaches are also discussed. In Lesson 2: Substance Use, participants learn about common substance use disorders among veterans, and discuss the relationship between mental health and substance use. Both lessons together aim to increase practitioners' competency in working with justice-involved veterans who may have mental health and/or substance use issues.

## Goals for the Instructor

- Introduce practitioners to trauma, including context and symptomology of military sexual trauma (MST), traumatic brain injury (TBI), and post-traumatic stress disorder (PTSD)
- Provide a brief overview of treatment approaches to trauma, including cognitive behavioral therapy (CBT), cognitive processing therapy (CPT), and rapid eye movement therapy
- Introduce practitioners to other mental health issues in veterans, including context and symptomology of depression, anxiety, suicidality, and adjustment disorder/stress response syndrome
- Introduce practitioners to substance use disorder, including context, symptomology, and treatment of alcohol use disorder and prescription drug abuse
- Provide a brief overview of treatment approaches to substance use disorder including contingency management and motivational interviewing

## Performance Objectives for Participants

- Gain insight into the context in which military service members experience trauma
- Learn about mental health disorders that affect veterans
- Recognize common symptoms of disorders prevalent in the veteran population
- Gain an understanding of effective treatment approaches to several mental health and substance use disorders

## References and Recommended Reading



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Hafemeister, Thomas L. and Stockey, Nicole A. (2010). Last Stand? The Criminal Responsibility of War Veterans Returning from Iraq and Afghanistan with Posttraumatic Stress Disorder, *Indiana Law Journal*: Vol. 85: Iss. 1, Article 3, 88-141. <http://www.repository.law.indiana.edu/ilj/vol85/iss1/3>

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Xue, C., Ge, Y., Tang, B., Liu, Y., Kang, P., Wang, M., & Zhang, L. (2015). A Meta-Analysis of Risk Factors for Combat-Related PTSD among Military Personnel and Veterans. *PLoS ONE*, 10(3), e0120270. <http://doi.org/10.1371/journal.pone.0120270>.

## Lesson 1: Mental Health

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### Lesson Preview:

After returning home, many veterans cope with significant mental health issues resulting from their service. Service members experience trauma in a variety of contexts which can lead to a variety of mental health challenges. In this lesson, participants will first gain an understanding of military trauma and related mental health conditions. Later in the lesson, participants will learn about several mental health screening tools validated for use with justice-involved veterans, as well as evidence-based approaches to treatment.

### Topics:

- Trauma in the Military (25 minutes)
- Military Sexual Trauma (5 minutes)
- Traumatic Brain Injury (10 minutes)
- Skills Building: Screening for TBI (5 minutes)
- Treatment for TBI (2 min)
- Post-traumatic Stress Disorder (20 minutes)
- Skills Building: Screening for PTSD (5 minutes)
- Skills Building: Criminal Responsibility Screening (5 minutes)
- Treatment for PTSD (15 minutes)
- Moral Injury (20 minutes)
- Comorbidity (10 minutes)
- Mood Disorders (5 minutes)
- Anxiety Disorders (5 minutes)
- Suicide (5 minutes)
- Adjustment Disorder/Stress Response Syndrome (5 minutes)
- Skills Building: Other Mental Health Screens (5 minutes)
- Barriers to Treatment (20 minutes)
- Mental Health Conclusion (2 minutes)


**Total Instruction Time:** 2 hours, 50 minutes

# Trauma in the Military

Time: 25 minutes

## Trauma in the Military

- Military sexual trauma (MST)
- Traumatic brain injury (TBI)
- Post-traumatic stress disorder (PTSD)
- Treatment approaches



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### Instructor:

The first lesson of this module is mental health. First, we will discuss the context in which service members experience trauma during their deployment to a combat zone, and how this typically affects them upon return. These experiences include posttraumatic stress disorder (PTSD), military sexual trauma (MST), and traumatic brain injury (TBI). We will also look at an introduction to treatment approaches for each issue. Later in this lesson, we will discuss other mental health concerns, such as depression, anxiety, suicide, and adjustment disorder.

## Trauma in the Military

- 2.7 million deployed to combat zones in Iraq and Afghanistan since 2001
  - More than 50,000 wounded as of 2017
  - Nearly 7,000 killed as of 2017
  - 970,000 have an officially recognized disability
- 20% of returning service members report symptoms of PTSD or major depression
  - Only 53% have sought treatment (stigma impact)
  - 19% report possible TBI and 7% report both TBI and PTSD

Source: Justice 4 Vets

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### **Instructor:**

Although people everywhere may endure a wide variety of traumatic experiences, veterans experience trauma in a unique context. Among veterans of the Iraq and Afghanistan wars, more than 50,000 have been physically wounded as of 2017. Additionally, many are affected by witnessing the deaths and injuries of civilians, “battle buddies,” and enemy combatants that have occurred since the beginning of these wars. Close to a million of these men and women have a disability recognized by the U.S. Department of Veterans Affairs. The United States has been in conflict since 2003, and the tempo and impacts of multiple deployments has had a large impact on returning service members.

It is estimated that 20% of these veterans suffer from PTSD and depression. Of those 20%, only 53% have sought treatment, and 19% report possible TBI. We will learn about how these issues present in veterans and review an introduction to treatment approaches.

## Trauma

- What is trauma?
- How do you think trauma might be experienced by military service members?
  - Consider generational differences
  - Consider demographic factors

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### Discussion Group:

Have participants break into small groups for discussion. Have them discuss the prompts for 5-10 minutes. Then, have each group share answers aloud, and facilitate a whole group discussion.

- What is trauma?
- How do you think trauma might be experienced by military service members?
  - Consider generational differences
  - Consider demographic factors



### Flipchart:

Make note of above answers/discussion on the flipchart.



### Instructor Note:

Remind participants of the generational differences and characteristics that were discussed in the Military and Veterans' Culture Module.



### Instructor:

Those are all great responses. The Diagnostic and Statistical Manual of Mental Disorders, better known as the DSM-5, defines trauma as “a psycho-emotional reaction to direct or indirect exposure to actual or threatened death, serious injury, or sexual violence.”

## Trauma

- Wounds of War:
  - Era differences
  - Not all combat-related



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### **Instructor:**

Now that you've generated a description of military trauma, I want to highlight specific types of traumatic events that service members experience. These are sometimes referred to as the "wounds of war," and just a warning: some of these descriptions are graphic and may be triggering.

Let's go back to our example of the experiences of veterans in the Vietnam War and the current wars in Iraq and Afghanistan. In Vietnam, the overwhelming number of casualties to combat troops was inflicted by small-arms fire, rockets, and mortars. A smaller number of injuries and deaths were caused by simple-to-make weapons, such as punji pits, which could disable a soldier or be fatal. A punji pit was a hole in the ground, filled with sharpened bamboo stakes covered with excrement, and camouflaged with jungle detritus. When a service member stepped into the pit, the punji stakes would penetrate the combat boot and foot, disabling the soldier. Infections were common.

In Iraq and Afghanistan, devices prepared by adversaries, called Improvised Explosive Devices, or IEDs, can cause serious injury or death through the effects of the explosion. IEDs are the leading cause of casualties in both conflicts. An IED is a bomb buried in the road, which has been covered and then detonated remotely, typically by a cell phone, or simply exploded as a half-track, tank, or other vehicle rolls over it. The resulting explosion can cause death, dismemberment, and/or TBI. So, the two eras experienced distinct types of injuries, each with their own context and circumstance. And yet, both groups experienced trauma, and are susceptible to its long-term effects.

Moreover, it's important to keep in mind that trauma may also result from non-combat related experiences. That is to say, trauma can be experienced by veterans in boot camp, during non-war periods, by witnessing deaths and seeing bodies, and through incidents like

	accidents, suicide, or homicide. It's important to account for and acknowledge that veterans who never served in combat may also have endured traumatic experiences.
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# Military Sexual Trauma

Time: 5 minutes

## Military Sexual Trauma (MST)

The U.S. Department of Veterans Affairs (VA) defines military sexual trauma, or MST, as **sexual harassment that is threatening or physical assault of a sexual nature**.

MST can happen during war, peace, or training. It can be committed by a person of any gender against a person of any gender.

- Among veterans using VA health care nationally:
  - About 25% of women and 10% of men report having experienced MST
  - MST is much more prevalent among women, although more than half of all veterans with MST are men

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### Instructor:

Another example of trauma that veterans may endure is what the VA has dubbed Military Sexual Trauma. This is a traumatic experience that includes sexual harassment or sexual assault while serving in the military during war, peace, or training. While it can be inflicted on men as well as on women, MST disproportionately affects women.

Among veterans who use the VA, about 1 in 4 women report having experienced MST, while only 1 in 100 men report the same. Even though women experience MST at much higher rates, men still account for a large number of victims, given that more than 80% of the active-duty military is male. When encountering veterans in our courts, it is important to keep in mind that they may have been affected by a variety of traumatic experiences, and to not make assumptions without proper assessment.

# Traumatic Brain Injury

Time: 10 minutes

## Traumatic Brain Injury (TBI)

- A TBI is caused by a blow, jolt, or a penetrating injury that disrupts the normal functioning of the brain
- Severity of injury is classified as mild, moderate, or severe
- Possibly 300,000+ from OEF/OIF
- Approximately 80% of TBIs are classified as mild (commonly known as a concussion)



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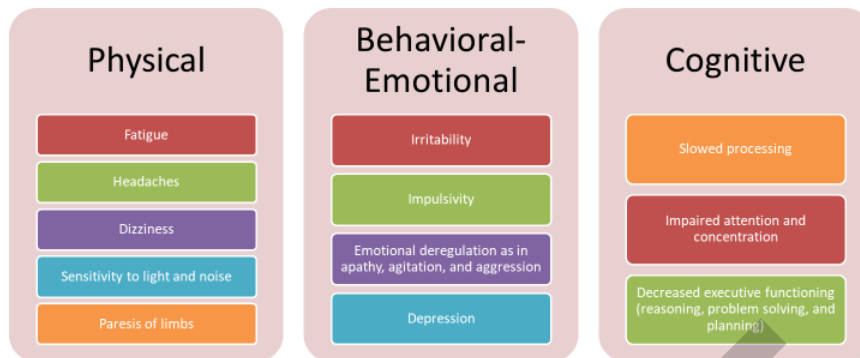
### Instructor:

Another common example of trauma in the military is traumatic brain injury, or TBI. A TBI is a serious injury that affects the normal functioning of the brain. The number of TBIs has significantly increased in the fighting in Afghanistan and Iraq as compared to wars of the 20<sup>th</sup> century because of the types of combat tactics that we talked about earlier. Blasts or blows from IEDs cause approximately 98% of TBIs.

Although exact numbers are difficult to discern, there have been approximately 300,000 TBIs from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF).

TBIs are typically classified as mild, moderate, or severe. The majority of TBI incidents in both the civilian and military population are classified as mild.

## Acute mTBI (mild) Symptoms



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### Instructor Note:

Do not read whole list.



### Instructor:

We'll now take some time to review symptoms for this common injury, which is a signature wound of war of the wars in Afghanistan and Iraq.

Acute symptoms for mild TBI, also known as mTBI, include physical, cognitive, and behavioral-emotional factors. These include fatigue, headaches, impaired executive functioning, and emotional deregulation. These symptoms are often self-reported, and as such can be unreliable.

Clinicians have developed more standard criteria for diagnosis, including loss of consciousness, loss of memory, altered mental state, neurological deficits, and intracranial lesions. Although everyone has a unique experience and recovery, most service members with an uncomplicated mild TBI recover within a few days to a month.

## Moderate to Severe Traumatic Brain Injury



About 15% of traumatic brain injuries are *moderate to severe*.

- Prolonged period of unconsciousness
- Hospitalization
- Longer recovery
- Many will develop long-term neurobehavioral or physical effects



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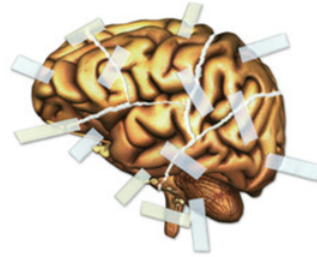


### **Instructor:**

While approximately 80% of TBIs are mild, around 15% are moderate or severe. These incidents typically involve a prolonged period of unconsciousness, hospitalization, and a longer recovery. Many veterans with this diagnosis will develop long-term neurobehavioral or physical effects, which are complicated by factors we will discuss now.

## Unique Military Context of TBI

- Repeated injuries
- Self-reported (under-reported)
- Delayed care
- PTSD-like symptoms



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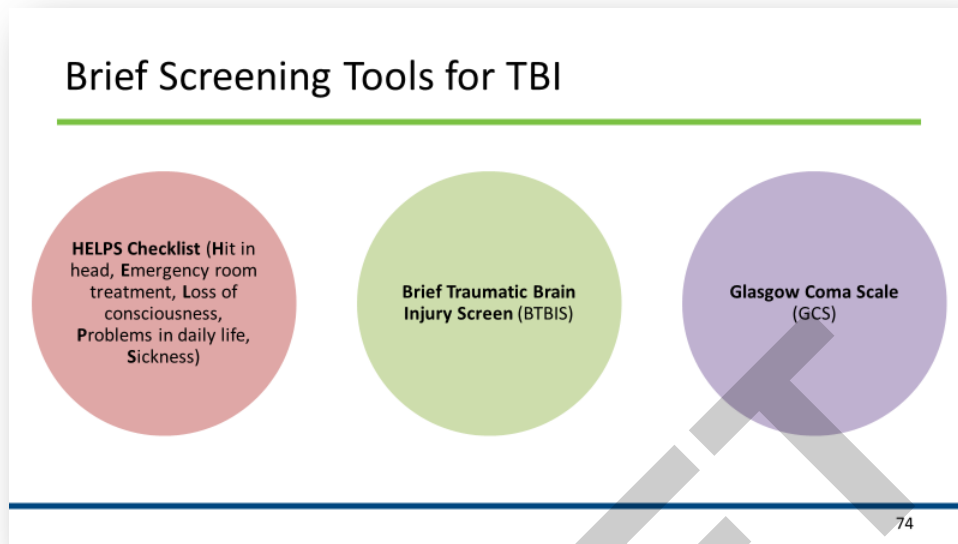
### **Instructor:**

Services members are more likely to sustain multiple mTBIs than the general population. Also, they may under-report their symptoms and thus fail to be diagnosed and treated due in part to the cultural factors we have learned about. They may also be unable to receive care immediately after the incident, as they may be in the midst of combat. In the civilian population, TBIs typically occur as isolated incidents with acute care, such as accidental falls and motor vehicle accidents.

Additionally, TBI diagnosis and treatment is further complicated for service members due to the nature of the symptoms being similar to and often conflated with symptoms of PTSD. In a few minutes we will learn about how PTSD presents in veterans. Keep these nuances in mind when you are working with veterans to ensure they receive the right types of treatment and referrals.

## Skills Building: Screening for Traumatic Brain Injury

Time: 5 minutes



### Instructor:

Moderate to severe forms of TBI are often relatively easy to identify and are likely to be documented in a veteran's service record, so the veteran or their records should be able to inform you if there's been a diagnosis. However, more subtle or mild forms of TBI may not be as evident, even though they can have serious implications for a veteran's health, welfare, and criminal case.

Criminal justice professionals should screen veterans for possible TBI and refer potentially positive cases for in-depth evaluation by trained and competent professionals.

Several brief screening scales have been developed to assess the severity and consequences of head injuries experienced by veterans. These screening tools may be used to determine whether further neurological or neuropsychological assessment by a medical expert is indicated. Examples of these tools include but are not limited to, the Glasgow Coma Scale (GCS), the Brief Traumatic Brain Injury Screen (BTBIS), and the HELP Checklist (**H**it in head, **E**mergency room treatment, **L**oss of consciousness, **P**roblems with concentration and memory, **S**ickness or other physical problems). These scales typically inquire about the length and severity, if any, of symptoms including:

- Coma
- Unconsciousness
- Post-traumatic amnesia (PTA)
- Alteration in mental state (e.g., feeling dazed, disoriented, or confused)
- Focal neurological deficits (e.g., impairments in attention, concentration, perception, speech, language processing, or executive functioning)

- Behavioral or emotional changes (e.g., irritability, quickness to anger, disinhibition, emotional lability)

Because several of these symptoms may be linked to unplanned or spontaneous criminal activity, it is essential to rule out TBI syndromes at the earliest possible stage in criminal justice proceedings. If an arrestee screens positive on one of these instruments and has not already been identified as having a TBI, he or she should be referred immediately to a neurologist, neuropsychologist, or comparable professional for further work-up. Such experts will almost always be available at a VA facility or VA-affiliated provider network for those who are VA eligible.

Brain injuries can have an impact on a person's legal defense—it's important, when working with a veteran with TBI, to get consent to talk to their lawyer, or encourage them to do it themselves, because the presence of TBI or PTSD could impact sentencing or even conviction.

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# Treatment for Traumatic Brain Injury

Time: 2 minutes

## Treatment for TBI

- Depends on severity
- Can include surgery, medication, hospitalizations
- Can include period of rehabilitation and possibly psychotherapy

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### Instructor:

Treatment for TBI depends on the severity of the injury. Mild TBIs (concussions) can typically be treated with rest and over-the-counter medication to treat headaches. Moderate and severe TBIs require treatment by a neurologist, and possibly a neurosurgeon, physical therapist, or other cognitive specialists. Treatment for moderate and severe TBIs might require surgery to minimize swelling and pressure, as well as medication and possible period of rehabilitation. Recovery could include physical therapy as well as psychotherapy to treat long term cognitive effects.

## Break

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## Post-Traumatic Stress Disorder



Time: 20 minutes

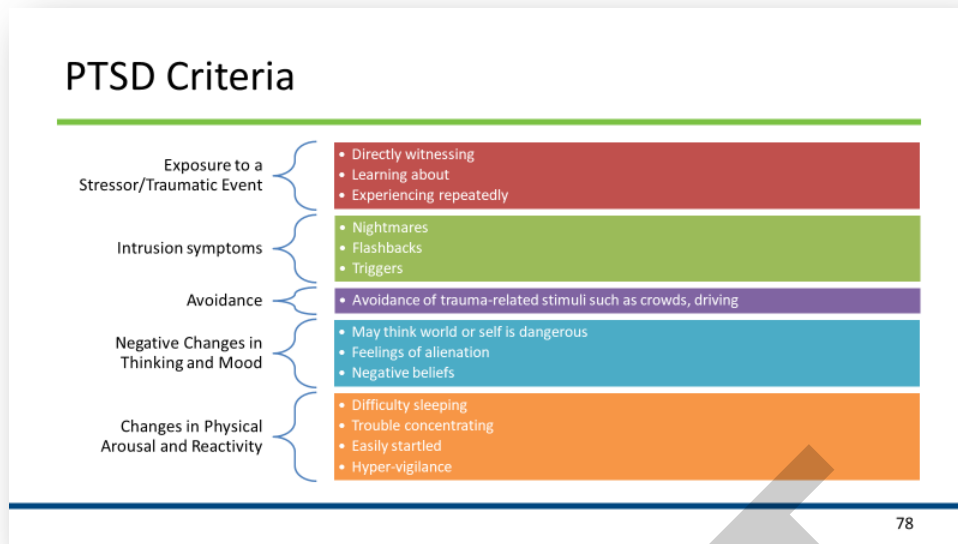
### Post-traumatic Stress Disorder

- What do you know about post-traumatic stress disorder (PTSD)?



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	<p><b>Ask:</b></p> <p>What do you know about PTSD?</p> <p><b><i>Anticipated Responses:</i></b></p> <p>A disorder in which people deal with the aftereffects of trauma; nightmares; triggers; insomnia; experienced by majority of veterans</p>
	<p><b>Flipchart:</b></p> <p>Note above answers/discussion on the flipchart.</p>



**Instructor:**

Listed here are specific criteria from DSM-5 used by clinicians to formally diagnose PTSD. They include direct or indirect exposure to a stressor or traumatic event.

Other criteria include what are called “intrusion symptoms,” which are ways in which people re-experience the traumatic event, through nightmares, dissociative states like flashbacks, and trauma-related stimuli, or “triggers.”

Additionally, PTSD diagnosis includes criteria for what’s called “avoidance behaviors,” in which a person avoids feelings or stimuli related to the trauma. Negative changes in thinking and mood, and changes in physical arousal and reactivity, are also indicators of PTSD.

## PTSD Risk Factors

Pre-event/static factors:	Characteristics of the trauma period:	Post-trauma
<ul style="list-style-type: none"> <li>• Female gender</li> <li>• Longer/more deployments</li> <li>• Prior trauma</li> </ul>	<ul style="list-style-type: none"> <li>• Severity</li> <li>• Witnessing injury or death</li> <li>• Discharging a weapon</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of support</li> </ul>

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### Instructor:

A meta-analysis of risk factors for combat-related PTSD among military personnel and veterans found several significant risk factors. A citation for this research can be found in the References and Reading section of this lesson in your Participant Manual.

Some of these risk factors include static characteristics, meaning that they are unchangeable or occurred before the trauma was experienced. For example, women, ethnic minorities, people with low education levels, people with longer and higher number of deployments, and prior trauma or adverse life experiences are more likely to be diagnosed with PTSD.

Risk factors also include characteristics of the trauma itself, such as severity of the event, direct combat exposure, witnessing an injury or death, and discharging a weapon. Risk factors also extend to circumstances after the trauma has occurred, such as availability and quality of support from family, friends, or healthcare and treatment providers. These risk factors are important to keep in mind when considering the unique circumstances of our clients.

## The PTSD Paradox for Veterans



In combat, PTSD-like reactions aid survival. If you do not learn to pair danger with effective response, you may not come home.

Aggression, emotional numbing, and denial of needs and pain, are essential to relationships within units and survival in war/military.

But, these same PTSD-like reactions:

- Can be dysfunctional for civilian life (relationships, careers, etc.)
- Must be 'unlearned'

Risk-seeking behaviors upon return:

- Adrenaline-oriented activity and extreme sports
- Fast driving/motorcycles, fights, drugs, firearms

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### Instructor:

Military service members employ a variety of tactics to survive the stressors and dangers of training or deployment. But when a service member returns home, these tactics can mirror some of the symptoms of PTSD, such as hyper-arousal and dissociation. Additionally, aggression, emotional numbing, and denial of needs and pain are essential to relationships within military units and survival in war. However, once service members return to civilian life, they need to “unlearn” these behaviors and learn adequate coping mechanisms to support recovery from trauma. We will discuss treatment approaches later in this section.

Many veterans may deal with the return to civilian life through risk-seeking behaviors that can quell their PTSD symptoms. These include adrenaline-oriented activities such as fast cars or motorcycles, fighting, or purchasing and using firearms. As we discussed earlier, some of these risk-seeking behaviors may increase a person’s likelihood of justice involvement.

## Skills Building: Screening for PTSD

Time: 5 minutes

### Skills-Building: Screening for PTSD

#### Brief screening tools for PTSD in the veteran population:

- PTSD Checklist—Military Version (PCL-M)
- Combat Exposure Scale (CES)
- Short Screening Scale for PTSD
- Trauma Screening Questionnaire (TSQ)
- The Deployment Risk and Resiliency Inventory (DRRI-2)

#### Structured diagnostic interviews:

- Clinician Administered PTSD Scale for DSM-5 (CAPS-5)
- PTSD Symptom Scale—Interview (PSS-I)
- Structured Clinical Interview for the DSM-IV Axis I Disorders (SCID PTSD Module)
- Structured Interview for PTSD (SI-PTSD)

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#### Instructor:

PTSD screening is an important step when working with veterans. There are several screening tools that have been validated for use with veterans. The full list may be obtained from the U.S. Dept. of Veterans Affairs National Center for PTSD. Examples of some of these brief PTSD screening tools include:

- PTSD Checklist – Military Version (PCL-M)
- Combat Exposure Scale (CES)
- Short Screening Scale for PTSD
- Trauma Screening Questionnaire (TSQ)
- The Deployment Risk and Resilience Inventory-2 (DRRI-2) (a broader screening tool that assesses a wider range of both risk factors and protective factors for PTSD and related disorders among military veterans. The DRRI-2 and validation studies on that tool can be obtained on the VA website).

Importantly, if a person screens positive on one of these instruments, this does *not* mean that he or she has PTSD or requires PTSD treatment. It simply means there is a sufficient basis to move forward, expend more resources, and conduct a more in-depth assessment to find out. Further assessments should be performed by a licensed or certified clinical professional who is trained to make mental health diagnoses, such as a licensed psychologist, physician, or clinical social worker.

Examples of structured diagnostic interviews that may be administered by these licensed and trained clinicians can be found on the VA website. They include but are not limited to the following:

- Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)
- PTSD Symptom Scale - Interview (PSS-I)
- Structured Clinical Interview for the DSM-IV Axis I Disorders (SCID PTSD Module)
- Structured Interview for PTSD (SI-PTSD)

As mentioned previously, brain injuries and PTSD may play a role in a defendant's legal case. Before we talk about treatment options for PTSD, let's take a quick minute to talk about criminal responsibility screening.

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# Mental Health and Criminal Responsibility

Time: 5 minutes

## Mental Health and Criminal Responsibility

- Under some circumstances PTSD and TBI are considered in law to be a mental disease or defect that can reduce or negate criminal responsibility
- Jurisdiction-based
- Provide relevant information to defense counsel

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### Instructor:

Under some circumstances, mental health issues such as PTSD and TBI are considered in law to be a mental disease or defect that can reduce or negate criminal responsibility. If a veteran's crime was the product of a "mental disease or defect," this might lessen or even negate his or her guilt for the crime. It may also reduce the severity of the charge or mitigate (lighten) the criminal sentence.

For example, if a veteran injured another person while he or she was experiencing severe anxiety and paranoia linked to a PTSD episode, this might lessen the offense from an intentional felony of battery to a misdemeanor offense of simple assault or disorderly conduct. Under the weight of such paranoid symptoms, the veteran may have (wrongly) believed that he or she was back in combat, and needed to protect him- or herself from enemies. In extreme and rare cases, this might even render him or her not guilty by reason of insanity (albeit a temporary and contextual insanity).

The applicability of PTSD or TBI-related insanity defenses varies depending on the jurisdiction's applicable insanity test. In general, the availability of an insanity defense is limited to those defendants whose conditions involve "gross impairment in reality testing," which refers to symptoms like delusions or dissociation, whose presence would indicate an individual has "lost touch with reality." However, PTSD-related insanity defenses are rarely used, and even more rarely successful. More often, a veteran's service-related mental health disorder may be used to reduce the severity of a charge to a lesser-included

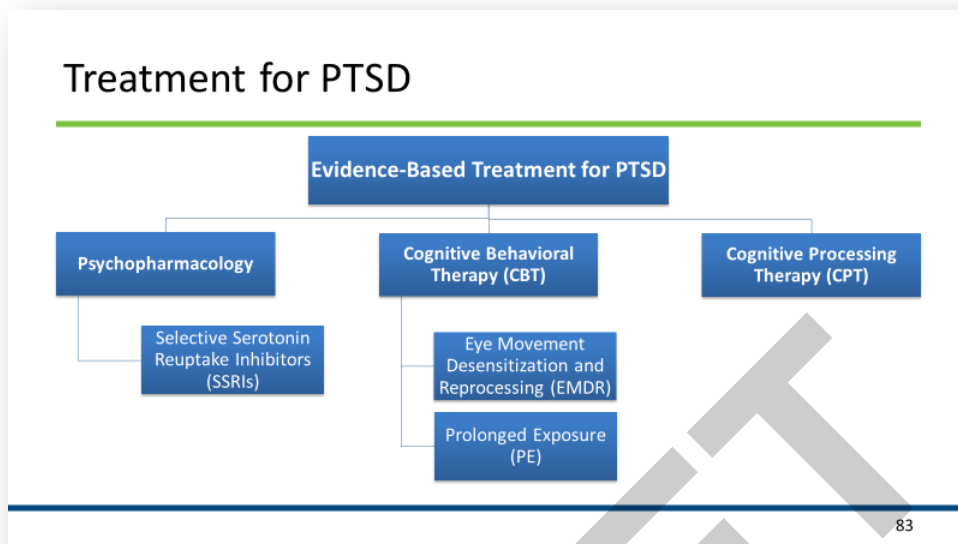
offense, or lessen a criminal sentence. This reduction in culpability can be substantial; it can, for example, represent the life-changing difference between a conviction of first-degree murder and manslaughter.

After obtaining informed consent to disclose the information, the results of all screenings and assessments should be made available to veterans' defense attorneys for consideration of its potential value at trial or sentencing hearings for reducing criminal responsibility or mitigating dispositions.

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## Treatment for PTSD

Time: 25 minutes



### Instructor:

Let's turn our attention now to treatment for PTSD. There are multiple treatment approaches that have been proven to be effective for PTSD in the military population. These include cognitive processing therapy, multiple forms of cognitive behavioral therapy, and psychopharmacological treatments. In working with justice-involved veterans with PTSD, it's important to be aware of the types of treatments they may be receiving, or to advocate for the use of these treatment modalities if they are not already in use. Let's take a closer look at some of these approaches.

## Cognitive Processing Therapy (CPT)

- Trauma-focused psychotherapy
- Teaches skills to think about trauma in new ways
- Helps facilitate understanding of connection between PTSD-related thoughts, feelings, and actions

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### **Instructor:**

Cognitive processing therapy, or CPT, is a treatment method commonly used by the VA and other providers to treat PTSD. CPT is a trauma-focused psychotherapy that helps clients learn more about their PTSD symptoms, and understand the connection between thoughts, feelings, and actions. It can help veterans learn how to think about their trauma in new ways.

## Cognitive Behavioral Therapy (CBT)

- Helps participants generate insight into thoughts, feelings, and actions
- Goal-directed
- Time-limited
- Structured
- Involves home exercises

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### **Instructor:**

Cognitive behavioral therapy, more commonly known as CBT, is an evidence-based psychosocial treatment approach. This approach is similar to CPT, but it provides a goal-directed, structured approach to how a person can modify their actions.

## Eye Movement Desensitization and Reprocessing (EMDR)

- Client accesses and processes traumatic memories while focusing on external stimuli (e.g. therapist's hand as it moves back and forth across the client's field of vision)
- Over time, PTSD symptoms are alleviated and new associations are formed
- EMDR.com (EMDR Institute)

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### **Instructor:**

Eye movement desensitization and reprocessing, or EMDR, is a therapeutic modality in which patients access and process traumatic memories while focusing on external stimuli, such as the therapist's hand moving back and forth in front of the patient's eyes. The focus on the external stimuli diminishes the impact of the trauma. Over time, PTSD symptoms are alleviated and new associations are formed.

## Prolonged Exposure (PE)

1. Education about treatment, common trauma reactions, and PTSD symptoms
2. Breathing exercises to mitigates distress
3. Talking through the trauma (imaginal exposure)
4. Real world practice (in vivo exposure)

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### **Instructor:**

Another treatment approach that is commonly used by treatment providers and the VA to treat PTSD is prolonged exposure therapy. This involves educating the client about treatment goals, common trauma reactions, and PTSD symptoms. Breathing techniques are used to aid relaxation and mitigate distress. Talking through the trauma, or imaginal exposure, can be helpful in order for the client to imagine the stimuli in a safe environment. Real-world practice with trauma-related stimuli, or *in vivo* exposure, is also a major part of this technique.

## Psychopharmacology

- Antidepressants (SSRIs and SNRI)
- The most effective in treating PTSD:
  - Sertraline (Zoloft)
  - Paroxetine (Paxil)
  - Fluoxetine (Prozac)
  - Venlafaxine (Effexor)

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**Instructor:**

Research has shown that a class of drugs called selective serotonin reuptake inhibitors, or SSRIs, can be effective in treating PTSD. Although these drugs are typically used to treat depression and anxiety, the FDA has approved their use for PTSD. SSRIs effect the neurotransmitter serotonin, which is believed to contribute to feelings of happiness. Physicians may prescribe Zoloft or Paxil. Since 89% of veterans with PTSD who are treated by the VA are prescribed SSRIs, it is therefore important to ask about the medications clients are taking and note any effects they may be having.

# Moral Injury

Time: 20 minutes

## Moral Injury



### Instructor Note:

Participants will learn about the concept of “moral injury” through viewing video clips of the documentary *Almost Sunrise*, which tells the story two young Iraq war veterans struggling to heal their own moral injuries while bringing awareness to veteran suicide as they trek from Wisconsin to California. To prepare, it’s advisable for the instructor to view the select video clips prior to instruction.



### Instructor:

By now you are familiar with several significant mental health issues many veterans must cope with after returning home. Recently, the concept of moral injury has garnered increased attention among clinicians and researchers seeking to understand the impact that military experience has on service-members and their mental health afterwards.



### Ask:

What do you know about moral injury? Have you heard about moral injury, in the context of your work with justice-involved veterans or elsewhere?







### Anticipated Responses:




Responses will vary.



### Instructor:

For a while, mental health practitioners working closely with veterans struggled to understand and respond effectively when experiences in the military resulted in levels of guilt and shame not well explained in terms of diagnoses such as PTSD. The concept of moral injury first emerged to explain practitioners’ observation that evidence-based PTSD treatments failed to

	<p>address veterans’ feelings of guilt and shame, even after extensive trauma processing. Practitioners began to employ the concept as a means of acknowledging that the clinical definition of PTSD fails to address the entirety of an individual’s psychological injury post-deployment.</p>
	<p><b>Multimedia:</b>            Play Clip #1: “What is moral injury?” (3:47 min.)  <a href="http://www.pbs.org/pov/almostsunrise/video/almost-sunrise-what-moral-injury/">http://www.pbs.org/pov/almostsunrise/video/almost-sunrise-what-moral-injury/</a></p>
	<p><b>Instructor Note:</b>            This clip begins at 0:00 with a definition of moral injury as a “wound to the soul, caused by participation in events that violate one’s deeply held sense of right and wrong.” It leads into a conversation between Tom, one of the veterans featured in the film, and a monk talking about how Tom’s actions in the military haunt him, and how his pain might be treated. It concludes at 3:47.</p>
	<p><b>Instructor:</b>            The U.S. Department of Veterans Affairs states that “the key precondition for moral injury is an act of transgression, which shatters moral and ethical expectations that are rooted in religious or spiritual beliefs, or culture-based, organizational and group-based rules about fairness [and] the value of life.”</p>
	<p><b>Ask:</b>            Considering what you know now about the unique aspects of military trauma, can you think of any “acts of transgression” that might result in moral injury for veterans?</p> <p><b>Anticipated Responses:</b>            Responses will vary. Possible correct responses include:</p> <ul style="list-style-type: none"> <li>• Using deadly force in combat, knowingly but without alternatives, or accidentally</li> <li>• Giving orders in combat that result in the injury or death of a fellow service member</li> <li>• Failing to provide medical aid to an injured civilian or service member</li> <li>• Failing to report knowledge of military sexual trauma (MST) experienced by oneself, another service members, or civilians</li> <li>• A change in belief about the necessity or justification for war, during service or after returning home</li> </ul>
	<p><b>Multimedia:</b>            Play Clip #2: “Diagnosing moral injury.” (3:42. min.)  <a href="http://www.pbs.org/pov/almostsunrise/video/almost-sunrise-diagnosing-moral-injury/">http://www.pbs.org/pov/almostsunrise/video/almost-sunrise-diagnosing-moral-injury/</a></p>
	<p><b>Instructor Note:</b>            At 21:30, Tom and Anthony meet a policeman who shares that police officers have suicide rates similar to those of vets. He explains how he has learned to cope with his emotions. The</p>

	clip ends at 25:12, when Tom's girlfriend describes how the military measures and defines PTSD and how it differs from moral injury.
	<p><b>Ask:</b></p> <p>How does the military define and measure PTSD? How does this differ from moral injury?</p> <p><b>Anticipated Responses:</b></p> <p>Responses will vary.</p>
	<p><b>Instructor:</b></p> <p>Broadly defined, moral injury is a form of suffering caused by committing, witnessing, or personally experiencing an act that violates one's moral beliefs or expectations. Precise definitions of moral injury continue to evolve, and the question of whether it should be classified as an official disorder remains a source of debate among mental health professionals.</p> <p>Some mental health professionals speculate that the enduring guilt and shame characteristic of moral injury result from an individual's thoughts and interpretations about a traumatic event, rather than from the traumatic event itself. This could provide one possible explanation for practitioners' frequent observation that evidence-based treatments for PTSD fail to ameliorate the feelings of guilt and shame veterans often struggle with.</p> <p>In any case, moral injury expands our understanding of military trauma and deepens our empathy for the unique challenges returning veterans face. Moral injury may explain the prevalence of mental health and substance use issues facing justice-involved veterans. For those who work closely with these veterans, therefore, continued research into these links may provide useful information to inform our policy, prevention, and intervention efforts.</p> <p>Now that we understand the types of traumatic experiences veterans endure during their service, including traumatic brain injury and military sexual trauma, as well as symptoms and treatment approaches for PTSD, let's take a break and when we return, we'll learn about other mental health issues.</p>
	<p><b>References and Recommended Reading:</b></p> <p><i>The Atlantic</i>: "Healing a Wounded Sense of Morality"  <a href="http://www.theatlantic.com/health/archive/2015/07/healing-a-wounded-sense-of-morality/396770/">http://www.theatlantic.com/health/archive/2015/07/healing-a-wounded-sense-of-morality/396770/</a></p> <p><i>Huffington Post</i>: "A Warrior's Moral Dilemma"  <a href="http://projects.huffingtonpost.com/projects/moral-injury">http://projects.huffingtonpost.com/projects/moral-injury</a></p> <p><i>The New York Times</i>: "War Wounds That Time Alone Can't Heal"  <a href="https://well.blogs.nytimes.com/2016/06/06/war-wounds-that-time-alone-cant-heal/">https://well.blogs.nytimes.com/2016/06/06/war-wounds-that-time-alone-cant-heal/</a></p> <p><i>The New York Times</i> "What We're Fighting For"</p>

<https://www.nytimes.com/2017/02/10/opinion/sunday/what-were-fighting-for.html>

U.S. Department of Veterans Affairs: "Talking Spiritual About Moral Injury" [https://www.va.gov/health/NewsFeatures/2016/July/Talking\\_Spiritual\\_about\\_Moral\\_Injury.asp](https://www.va.gov/health/NewsFeatures/2016/July/Talking_Spiritual_about_Moral_Injury.asp)

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## Break

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# Comorbidity

Time: 10 minutes

## Comorbidity

- Majority of those with PTSD are diagnosed with at least one other disorder, and many have at least three other diagnoses
- Simultaneous diagnoses can exacerbate the conditions of each
- Most common conditions with PTSD: substance use, depressive, and anxiety disorders

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### Instructor:

Now that we've had a break, we'll move on to discuss other mental health issues. While trauma and PTSD are a major part of the mental health experience of many veterans, mood and substance use disorders are also common. Many veterans are diagnosed with multiple co-occurring conditions, which is referred to as "comorbidity." This can often complicate treatment, and it can be challenging for people to manage a multitude of symptoms at once. Let's take a look at this in a bit more detail.

## Prevalence of Medical & Psychiatric Needs in Military Veterans

Any medical or mental health disorder	>50%
Any mental health disorder	10%-35%
Any substance use disorder	7%-17%
Co-occurring substance use and mental health disorder	10%-16%
Post-traumatic stress disorder (PTSD)	10%-20%
Probable traumatic brain injury	19%
Clinical depression	15%
Anger outbursts	41%
Relationship problems with spouse or romantic partner	45%
Military sexual trauma (MST)	22% of women

Sources: Ghahremanlou-Holloway et al. (2011); Ilgen et al. (2012); Kemp (2012); McCormick

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### Instructor:

The majority of those diagnosed with PTSD have at least one other condition, and many have three other diagnoses.

As we can see from this chart, the most common of these other disorders are substance use disorder, depressive disorders, and anxiety disorder. We will spend time reviewing these other conditions that veterans potentially experience.

## Other Mental Health Considerations in Veterans

- Mood disorders
- Anxiety disorders
- Suicide
- Adjustment disorder/stress response syndrome
- Barriers to treatment

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### **Instructor:**

The topics we will cover in this section are mood disorders, anxiety disorders, suicide, adjustment disorder, and barriers to treatment. Keep in mind that trained clinicians will be best suited to treat these conditions, however, all of us can be mindful of the types of diagnoses, symptoms, and approaches and barriers to treatment.

# Mood Disorders

Time: 10 minutes

## Mood Disorders

### Spectrum of diagnoses

- Major depressive disorder
- Persistent depressive disorder (dysthymia)
- Medical or substance-induced depression

### Symptoms

- Feelings of sadness, hopelessness, self-hatred
- Diminished interest or pleasure in activities
- Fatigue, dysregulated sleep, impaired concentration

### Treatment approaches

- CBT
- Antidepressants

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### Instructor:

Depression is a condition that affects hundreds of millions of people around the world every year, and veterans are not immune to its effects. Veterans may have been diagnosed with or have been suffering from the effects of depression before they enlisted, as well as during their service, or after they are discharged.

There are a variety of depressive disorders that have varying presentations. There is major depressive disorder, which is marked by a prolonged period of depressed mood and other symptoms which have a significant impact on a person's functioning. There is persistent depressive disorder, or dysthymia, which is a more chronic but less severe condition than major depressive disorder. There are also several depressive disorders which are qualified as being "induced" by either a medical condition or substance misuse.

Symptoms for depressive disorders vary, but mostly include feelings of sadness, hopelessness, diminished interest in any or all activities, and physical symptoms such as fatigue and impaired concentration.

Depression is also marked by its ability to significantly impact a person's relationships, work life, and other facets of functioning.

Although there is no "cure" for depression, and individuals may experience the condition repeatedly throughout their lifetime, there are several ways to manage it. One commonly used psychotherapeutic approach, which has the strongest evidence base, is cognitive behavioral therapy, or CBT, which we just learned about. This modality can help patients reorient their cognition as well as change behaviors. Another approach to managing

depression is the use of anti-depressants which, while effective, should not be used as the one and only treatment. Physical exercise and strong social support can also be useful in the management of depression.

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# Anxiety Disorders

Time: 5 minutes

## Anxiety Disorders

- Spectrum of diagnoses**
  - Generalized anxiety disorder (GAD)
  - Specific phobias
  - Post-traumatic stress disorder (PTSD)
- Symptoms**
  - Fear, panic, excessive worry
  - Restlessness, irritability
  - Acute: chest pain, increased heart rate, difficulty breathing
- Treatment approaches**
  - CBT
  - Anxiolytics
  - Stress management

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### Instructor:

Anxiety is a condition that also affects millions. We have already learned about how one type of anxiety disorder, PTSD, can affect veterans. In addition to PTSD, veterans may also experience generalized anxiety disorder, specific phobias, or several other types of anxiety disorders.

These conditions are marked by both acute and long-term symptoms such as fear, panic, excessive worry, and physical symptoms like restlessness, chest pain, and increased heart rate. While many of these symptoms may be appropriate in certain dangerous situations, people with anxiety disorders have fears or worries that are out of proportion with the objective threat of the situation.

Treatment approaches for anxiety include CBT, as well as stress management techniques that can be done in treatment and on one's own. Anxiolytics, or medications that treat anxiety, SSRIs, and antidepressants may also be prescribed in some situations.

# Suicide

Time: 5 minutes

## Suicide

- Suicide rates in veterans:
  - In 2014, an average of 18-20 veterans a day committed suicide
  - Two-thirds were older than 50
  - Most used a firearm
- Risk factors: depression, substance use disorders, older, female
- Prevention:
  - Screening and assessment
  - Veterans Crisis Line 1-800-273-TALK (8255), then press 1
  - Effective VA, community-based, and telemental health services

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### Instructor:

Suicide unfortunately affects veterans at higher rates than the civilian population in the United States. Tragically, in the latest year we have data for, 2014, an average of 18-20 veterans a day committed suicide. A common misconception is that the majority of veterans who commit suicide are from the most recent wars in Afghanistan and Iraq. However, fully two-thirds of these individuals were older than 50, and most used a firearm.

Risk factors for suicide in veterans include mental health disorders such as depression, substance use disorders, and older age and female gender.

In the criminal justice field, one approach to suicide prevention is careful screening for suicidality followed by in-depth assessment where appropriate. We can also encourage veterans to utilize the 24/7 Veterans Crisis Line, where they can speak with trained counselors, and which has answered approximately 2.5 million calls. Additionally, as with the civilian population, effective mental and behavioral health services, whether through the VA, community-based providers, or telemental health conferencing, can be used to mitigate the risk of suicide.

## Adjustment Disorder/Stress Response Syndrome

Time: 5 minutes

### Adjustment Disorder/Stress Response Syndrome

- Context**
  - Life change
  - Traumatic event
  - Short-term
- Symptoms**
  - Similar to those of depression and anxiety
  - Symptoms impede regular functioning
- Treatment approaches**
  - Psychotherapy
  - Psychopharmacology

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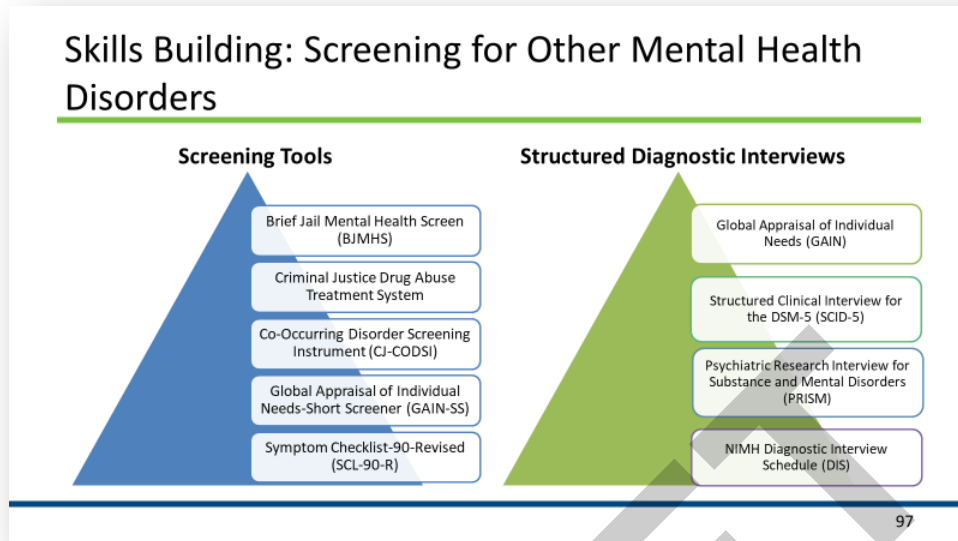
### Instructor:

Many veterans may also experience a condition called adjustment disorder or more recently known as stress response syndrome. This condition occurs for a short period of time after an individual undergoes a major life change, or a traumatic event. This event does not necessarily have to be related to the veteran's time in the military. The symptoms of this disorder are like those of depression and anxiety disorders, the difference being that they occur in reaction to a specific event, and usually only last for a short period. These symptoms also seriously impede a person's functioning.

Like with depression and anxiety, psychotherapy is a frontline treatment for this condition. Psychopharmacology may also be used if appropriate.

## Skills Building: Other Mental Health Screens

Time: 5 minutes



### Instructor:

In addition to PTSD, brief screening tools have been developed and validated for use in jail or court settings for other types of mental health and substance use disorders. These include but are not limited to:

- Brief Jail Mental Health Screen (BJMHS)
- Criminal Justice Drug Abuse Treatment System
- Co-Occurring Disorder Screening Instrument (CJ-CODSI)
- Global Appraisal of Individual Needs-Short Screener (GAIN-SS)
- Symptom Checklist-90-Revised (SCL-90-R)

For individuals who screen positively on these scales, more in-depth diagnostic assessments should be performed by a trained and qualified mental health professional. Examples of structured diagnostic interviews that may be administered by credentialed clinical professionals include but are not limited to:

- Global Appraisal of Individual Needs (GAIN)
- Structured Clinical Interview for the DSM-5 (SCID-5)
- Psychiatric Research Interview for Substance and Mental Disorders (PRISM)
- NIMH Diagnostic Interview Schedule (DIS)

## Barriers to Treatment

Time: 20 minutes

### Barriers to Treatment

**Discuss:**

What are reasons a veteran might not seek treatment?



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**Discussion Group:**

Divide participants into discussion groups.

Ask groups to discuss in groups for 5 to 10 minutes:

- What are reasons a veteran might not seek treatment?
  - Consider cultural factors

After 5-10 minutes, facilitate a whole group discussion for 10 minutes by asking each group to report back on their discussion. If the group doesn't cover the following topics, mention that they are all reasons why veterans may not seek treatment:

- Military culture values strength over weakness (warrior ethos)
- Misinformation about ways treatment can help
- Stigma in general about mental health

# Mental Health Conclusion

Time: 2 minutes

## Conclusion

- The unique context of trauma in the military
- Multiple co-occurring disorders can complicate symptoms and treatment
- Screening, assessment, and treatment are important and effective despite potential barriers

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### Instructor:

We have covered a wide array of topics in this lesson. We discussed the unique circumstances under which military service members and veterans experience trauma, including the pervasiveness of military sexual trauma, the frequency IEDs explosions connected to traumatic brain injuries, and ubiquity of post-traumatic stress disorder.

Another important consideration we covered in this lesson was the impact of co-occurring disorders, which, as we now know, is very common in veterans. Treatment providers need to assess and prioritize the treatment of multiple symptoms in order to best care for veterans.

Although trauma and mental health issues are common and persistent, effective screening and evidence-based treatment are important in helping veterans to function successfully.

We will now break for the day and then move on to our lesson on substance use tomorrow morning.

## Break for Day

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# **VICTOR**

## **DAY 3**

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## Lesson 2: Substance Use

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### Lesson Preview:

Substance use disorders (SUDs) are a significant issue for justice-involved veteran populations. This issue is further compounded by the fact that many veterans with substance use issues also struggle with co-occurring mental health conditions, many of which were discussed in the previous lesson. In this lesson, participants will learn about alcohol use disorder and prescription drug abuse, two of the most common substance use disorders among military veterans. This lesson also highlights several SUD screening tools and evidence-based interventions.

### Topics:

- Substance Use Disorders in Veterans (5 minutes)
- Alcohol Use Disorder (5 minutes)
- Prescription Drug Abuse (10 minutes)
- Substance Use Disorder Treatment: Continuum of Care (5 minutes)
- Substance Use Disorder Treatment: Contingency Management Approach (5 minutes)
- Substance Use Disorder Treatment: Motivational Interviewing (10 minutes)
- Active Listening (35 minutes)
- Conclusion: (5 minutes)

**Total Instruction Time:** 1 hours, 20 minutes

## Substance Use Disorders in Veterans

Time: 5 minutes

### Substance Use Disorders in Veterans

- Affects millions globally
- Comorbidity: many people diagnosed with mental health conditions also have a co-occurring substance use disorder
- Prevalence: In the wars in Iraq and Afghanistan, about 1 in 10 returning soldiers seen in VA have a problem with alcohol or other drugs.

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#### Instructor:

As with mental health issues, substance use is an issue that affects millions around the world. Veterans you encounter in your courts may also struggle with substance use issues. Historically, there have been many different terms used to describe substance use issues, both in the general public, and in professional practice. In general, we can think of substance abuse as the behavior that may lead to substance dependence, addiction, and substance use disorder. However, in 2013, the DSM-5 replaced the terms “substance abuse” and “substance dependence” with “substance use disorder.”

As we have learned, many people diagnosed with mental health conditions also have a co-occurring substance use disorder. Substance use disorders can present differently in each person but are typically marked by disruption or impairment of one’s functioning and a dependence on the substance. While the research varies on the exact prevalence of the disorder among veterans, it is well documented that a significant number of veterans have been diagnosed with and treated for substance use disorder over the course of many decades.

Veterans face many of the same obstacles in dealing with this disorder as the general population, including stigma, lack of resources, and increasing prevalence of prescription drug abuse. We will now discuss two of the most commonly misused substances in the veteran population: alcohol and prescription drugs.

# Alcohol Use Disorder

Time: 5 minutes

## Alcohol Use Disorder

- Severity based on criteria: withdrawal symptoms, intense cravings, risking safety, and inability to control consumption
- Screening tools
  - AUDIT
  - CAGE
- Collateral consequences: disruptive effect on a person's relationships, career, and finance

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### Instructor:

Alcohol use disorder is a condition that affects many veterans. As we know, it can be comorbid with other disorders, and is especially prevalent in veterans with PTSD. As with trauma, it is important to keep in mind that veterans may struggle with alcoholism before, during, or after their service.

The DSM-5 measures the severity of a person's alcohol use disorder through the categories "mild," "moderate," or "severe." These classifications are based on the number of criteria a person meets. These criteria include having withdrawal symptoms, intense cravings, risking safety, and inability to control consumption.

There are many different screening techniques that may be used to screen for alcohol use disorder in clients, such as the AUDIT, or Alcohol Use Disorders Identification Test, which is a brief 10-question assessment; and the CAGE, which measures responses to questions about cutting down on use, if others have been annoyed by a person's use, guilt, and if the person uses alcohol in the morning as an eye-opener. These screening tools, among many others, are widely available.

Alcohol use disorder in veterans may also have a range of collateral consequences. These can include the alcohol's effect on the person's other symptoms, as the disorder is typically comorbid. Alcoholism is also notable for its disruptive effect on a person's relationships, career, and finances. These are important to keep in mind when assessing a veteran for this disorder.

# Prescription Drug Abuse

Time: 10 minutes

## Prescription Drug Abuse

- Special circumstances for veterans:
  - DoD zero tolerance policy
  - Stigma
  - Rise in number of pain reliever prescriptions
  - Behavioral health issues/medication
- Initiatives to combat overuse of opioids



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### Instructor:

Veterans are also susceptible to illicit drug abuse. In particular, prescription drug abuse has taken a toll in the veteran population, as with the general population. The Department of Defense instituted a zero-tolerance policy for illicit substances in the 1980s, with serious consequences—such as dishonorable discharges—for failed random drug tests. Likely as a result, the rate of illicit drug use has remained constant for active-duty personnel since the policy went into effect. However, this policy, coupled with the general stigma about drug use and treatment, deters active-duty personnel from discussing substance abuse or seeking treatment. As the servicemember transitions to civilian life, the many stressors of reintegration may perpetuate substance use.

A report from The National Institute on Drug Abuse, indicates that prescriptions for pain relievers by military physicians increased to almost 4 million within an 8-year span. This considerable number of prescriptions between 2001 and 2009 led to a growing problem of opioid abuse in the active-duty and veteran population. In fact, in 2011, veterans were twice as likely to die from accidental opioid overdose than civilians. Combat-related injuries can partly explain this phenomenon, as a considerable number (~40-60%) of military personnel experience chronic pain. This chronic pain can be brought about from grueling endurance tasks, such as long treks, carrying heavy equipment, or injuries. Chronic pain can be debilitating and difficult to treat, and in lieu of adequate treatment, some veterans may turn to misusing other substances to cope with the pain. Although this population has extenuating circumstances, the rise in prescriptions by military physicians and the VA can also be compared to the general trend in the civilian population of doctors

over-prescribing opioid medication.

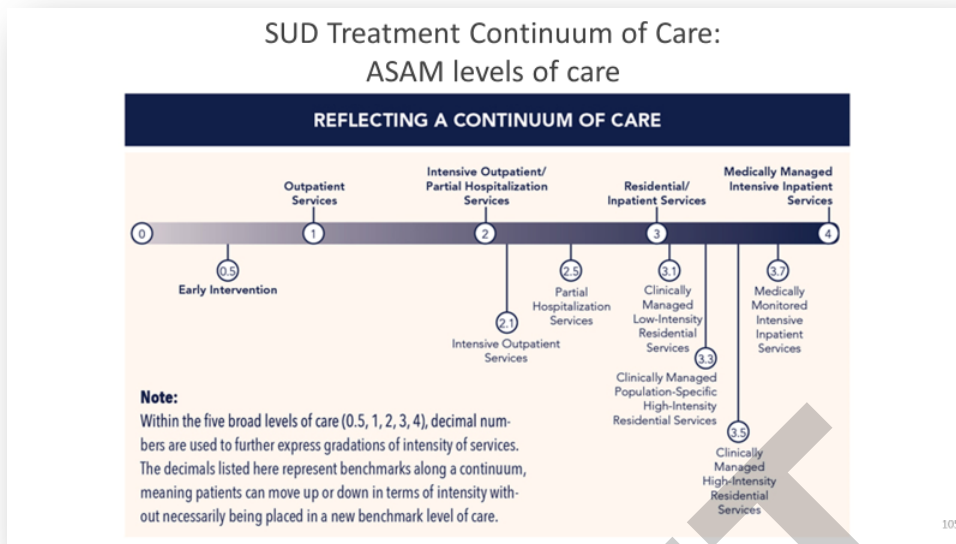
Additionally, it's important to keep in mind that many veterans with opioid prescriptions may have psychiatric comorbidities or medical conditions, requiring other medications. Combining substances, along with the stressors of mental health issues, has contributed to a high suicide rate among veterans, and has been a focal point in the effort to reduce suicide and accidental overdose by veterans.

The rise in opioid abuse in this population has not gone unnoticed. The federal government and the VA have acted to combat the overuse of opioids, and have sponsored several initiatives. One such initiative is the Veterans Overmedication Prevention Act, which was introduced in Congress in 2017 and calls for more research on the high volume of opioid prescriptions and its relation to veteran suicide and overdose rates. Another such initiative is the VA's Opioid Safety Initiative, which since 2013 has helped reduce the number of veterans that are prescribed opioids by 25%, in part by promoting the use of other pain management therapies.

Because there are so many factors to consider when thinking about opioid abuse in the veteran population, keep in mind that effective screening, assessment, holistic evidence-based treatment, and coordinated care, can be effective in combating abuse. We talked about screening for substance use disorders in a previous section, so now we'll transition to talking about treatment for substance use disorders.

## SUD Treatment: Continuum of Care

**Time: 5 minutes**



**Instructor:**

Treatment for substance use disorders is typically conceived of as a continuum of care. The American Society of Addiction Medicine has outlined five recovery-oriented levels of care that correlate to multidimensional assessments for clinicians. Although there are many specific gradations of care, the five levels are: early intervention, outpatient, intensive outpatient, residential inpatient, and medically managed intensive inpatient. These levels are a helpful guideline to understanding individualized care, and that substance use disorder treatment occurs on a spectrum.

Some evidence-based approaches to substance use disorders that might be used along this continuum of care include cognitive behavioral therapies, which we learned about in the last lesson, and contingency management approaches and motivational interviewing, which we will discuss next.

## Contingency Management Approach

Time: 5 minutes

### Contingency Management Approach

- Using the community to support/reward positive behaviors to encourage participants to make healthier lifestyle changes
- Reinforcement of a substance free/prosocial lifestyle competes with the substance misuse lifestyle
- Use of contracts, tokens, and treatment plans



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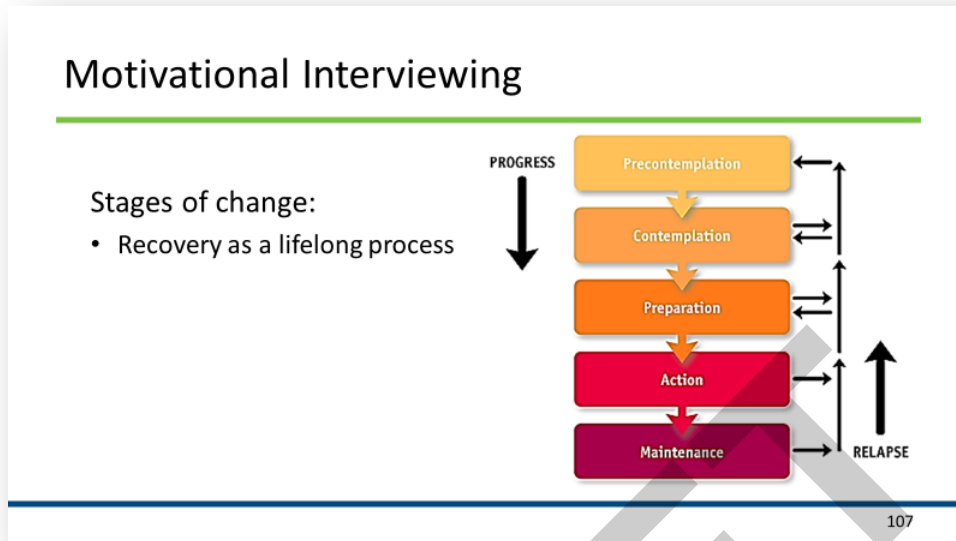


#### **Instructor:**

The contingency management approach is used in substance use treatment by providing clients with positive rewards to reinforce positive behaviors, like abstinence. Often, the community or group is used to support and reward clients to reinforce a prosocial, substance free lifestyle. Clinicians can shape client behavior by using contracts, tokens, or treatment plans to encourage behavioral change and keep clients on track. An example of this type of approach includes voucher-based systems in which clients are rewarded with a voucher that has monetary value, such as for the movies or food, once they submit a substance-free urine sample. As clients submit more consecutive substance-free samples, the vouchers can increase in value, thus encouraging clients to remain substance-free.

# Motivational Interviewing

Time: 10 minutes



**Instructor:**

Recovery from substance use disorder can be a complicated process. In most cases, it is not a linear experience. As we mentioned, veterans you may encounter in your courts may have dealt with substance use issues before their enlistment, during their service, and after their return. They may have attempted recovery many times, or they may not ever have sought treatment.

Treatment providers may use an evidence-based practice known as motivational interviewing when working with individuals with a substance use disorder. With this technique, the clinician can determine what so-called “stage of change” a person is in. These stages provide a framework for a person’s thinking about, or readiness for, treatment.

These stages include pre-contemplation, wherein a person does not yet think it’s necessary for them to change; contemplation, in which a person is considering the pros and cons of seeking treatment; preparation, in which a person begins to plan how they will change; action, in which a person begins changing their behavior; and maintenance or relapse prevention, in which a person attempts to maintain the new behaviors.

In this framework, it is possible to fall back into previous steps, or regress, and it’s important to leave space for the inevitable difficulties of maintaining sobriety.

## Motivational Interviewing

- Goal-oriented, client-centered approach that helps clients explore and resolve ambivalence by using intrinsic motivation to encourage behavioral change.
- Meeting a client where she/he is – what motivates an individual?
  - Core skills: **OARS**
    - Open-ended questions
    - Affirmations
    - Reflections
    - Summaries



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### Instructor:

When using a motivational approach, clinicians use the client's intrinsic motivation to facilitate and engage them in order to encourage behavioral change. This technique is goal-oriented and helps clients explore and resolve ambivalence. It's important to acknowledge that clients may be very ambivalent or hesitant to make a change, and so clinicians must meet a client where they currently are in the process, rather than pushing them to make a change they are not ready to make.

The core skills that are used in motivational interviewing are: open-ended questions, affirmations, reflections, and summaries. Clinicians use these techniques to explore their client's ambivalence and encourage them to tell their story by asking open-ended questions. Affirmations are a key tool to acknowledging a client's strengths and building their confidence toward change. Reflective listening is helpful to build trust in the relationship and reduces the likelihood of miscommunication. Summaries are a way to transition the conversation by reporting back what the clinician heard as well as asking clarifying questions.

We'll now transition to an activity that will help us practice the skills used in motivational interviewing.



### Reference:


Homelessness Resource Center (HRC), Motivational Interviewing: Open Questions, Affirmation, Reflective Listening, and Summary Reflections (OARS)

<http://homelesshub.ca/resource/motivational-interviewing-open-questions-affirmation-reflective-listening-and-summary>

## Skills Building: Active Listening

Time: 25 minutes

### Skills Building: Active Listening



Think about a change you are contemplating making

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#### **Instructor:**

Think about a change you are contemplating making in your life, such as weight loss, quitting smoking, or pursuing higher education. It should be a change that you are still somewhat ambivalent about making.

Once you've thought of your change, pair up. One person should sit with their back facing the screen, while the other person should look directly at the screen.



#### **Instructor Note:**

Wait until everyone is in position before advancing the slide to the first set of instructions.

#### *Timing*

- Part 1: 7 minutes
- Part 2: 7 minutes
- Large group debrief: 6 minutes

## Active Listening, Part 1

After listening to your partner's "behavioral change," **DO** the following:

- Tell them **WHY** they should make this change
- Give them reasons why the change is important
- Tell them **HOW** to make the change
- Give them some guidelines on **WHEN** to start
- Encourage them; assure them that they can make the change; persuade them to do it

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### Instructor:

If your back is to the screen, you will be Speaker 1. Start the exercise by telling your partner about the change you are contemplating making and explain that it has been difficult for you. If you are facing the screen, you are Listener 1. Your job is to listen to your partner and do **ONLY** what is listed on the screen. Follow the instructions exactly. Do not do anything that is not listed. Take a minute to review the instructions before we begin.

OK, Speaker 1, begin. Explain to your partner the change you are contemplating making and why it has been difficult for you. Then, Listener 1, follow the instructions on the slide or in your Participant Manual.



### Instructor Note:

Set a timer for 5 minutes. Prior to calling time, walk around the room to see if any listeners are still working through the instructions. If groups are still working, add 2 minutes to the clock.

## Active Listening



SWITCH SEATS

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**Instructor:**

Time's up! Without discussing the exercise at all, switch seats, so that now Listener 1 is Speaker 2 and is sitting with their back to the screen, and Speaker 1 is Listener 2 and is sitting facing the screen.

## Active Listening, Part 2

After listening to your partner's "behavioral change," **ASK** the following:

- Why would you want to make this change?
- How might you go about it in order to succeed?
- What are the three best reasons for you to do it?
- How important is it for you to make this change, and why?
- So, what do you think you'll do?

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### Instructor:

Just like before, Speaker 2 will begin by explaining the change that they want to make and why it has been difficult, while Listener 2 will follow the instructions on the screen. Again, do not say or do anything that is not listed in the instructions. You will have 5 minutes. Listener 2, take a minute to review the instructions.

Begin.



### Instructor Note:

Set the timer for 5 minutes. Again, before announcing time, go around the room to see if any listeners are still working through the instructions. If groups are still working, add 2 minutes to the clock.

When the exercise has concluded, debrief with the whole group.



### Ask:

To the participants who were in the Speaker 1 group, tell us about your experiences.




### **Anticipated Responses:**

I didn't feel listened to; my listener seemed disinterested; they did most of the talking; they didn't seem to care what I thought; my listener just gave me a bunch of advice.



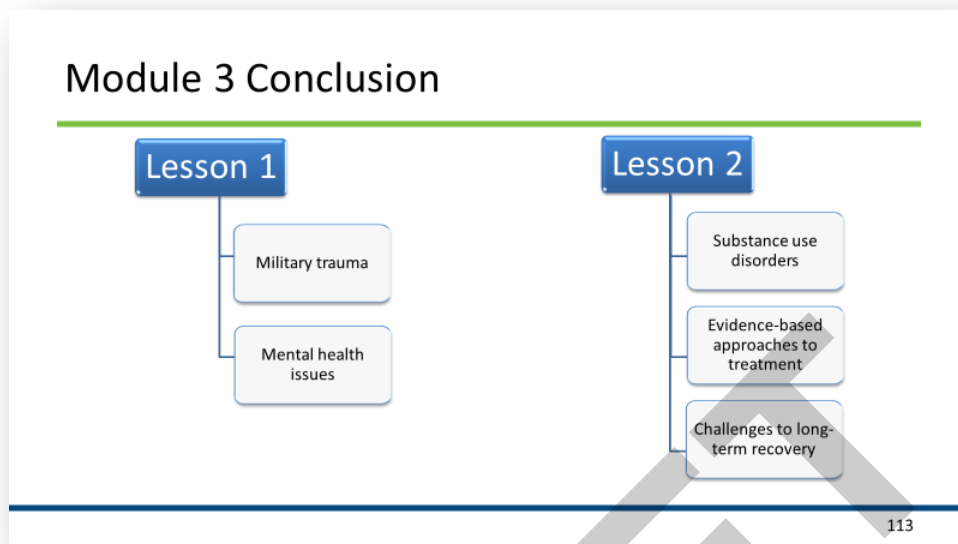
### Instructor Note:

Summarize participants' comments. Ask open-ended questions to help further the discussion (e.g., "What did the listener say or do that sent the message that they weren't listening?"). Use reflections to demonstrate understanding of the comments shared (e.g., "So you're saying that your listener's approach was not helpful to your change process?").

	<p><b>Ask:</b></p> <p>To the participants who were in the Speaker 2 group, please share your experiences.</p> <p><b><i>Anticipated Responses:</i></b></p> <p>My listener seemed genuinely concerned and interested in me/my issue; they got me thinking about some things I hadn't really thought about before; they let me do most of the talking; I felt heard.</p>
	<p><b>Instructor Note:</b></p> <p>Summarize participants' comments. Ask open-ended questions to help further the discussion (e.g., "How did your listener's approach communicate that they were genuinely concerned?"). Use reflections to demonstrate understanding of the comments shared (e.g., "It sounds like when your listener asked you why it was important to you to change, this was helpful to you and your change process. Have I got that right?").</p>
	<p><b>Ask:</b></p> <p>What are some differences between these two sets of instructions?</p> <p><b><i>Anticipated Responses:</i></b></p> <p>In the first set of instructions, the listener is <u>telling</u> the speaker what to do, why to do it, and how to do, while in the second set of instructions, the listener is <u>asking questions</u> about what the speaker wants to do, why it's important for the speaker to do it, and how the speaker might go about doing it. In the first set of instructions, the listener is giving advice, and they are coming off as judgmental, whereas in the second set of instructions, the listener seems to respect the speaker's opinions, thoughts, and concerns, and empowers the speaker to make their own decisions/choices.</p>

## Module 3: Conclusion

Time: 5 minutes



**Instructor:**

We have now reached the end of Module 3. We discussed mental health issues and substance use disorders, two significant issues for justice-involved veterans and the practitioners who work closely with them. One key point of this module is to understand that veterans have very high rates of comorbidity and may be dealing with several complex, related symptoms and diagnoses.

Now you'll take your end-of-module quiz before we take a brief break. Then, in Module 4, we will learn about the range of treatment-related services and resources available veterans.

## Module 3 Quiz

Time: 10 minutes

1. Briefly describe some of the contexts in which military service members experience trauma. In your response, provide at least one example each of combat and noncombat-related military trauma.

**Combat-related trauma:** Responses will vary; any physical “wound of war” is an acceptable answer

**Noncombat-related trauma:** boot camp, military sexual trauma (MST); witnessing instances of death/homicide/suicide

2. What substance use disorders are most prevalent among justice-involved veterans?

Alcohol use disorder, prescription drug abuse

3. Name three evidence-based treatments used with veterans suffering from PTSD.

Correct responses: Prolonged Exposure (PE); Cognitive processing therapy (CPT); Cognitive behavioral therapy (CBT); Eye movement desensitization and reprocessing (EMDR); SSRIs

4. Validated screening tools such as the Trauma Screening Questionnaire (TSQ) and Combat Exposure Scale can accurately identify veterans who require PTSD treatment.

TRUE

FALSE

Note: If a person screens positive, this does *not* mean that he or she requires PTSD treatment; it means there is a sufficient basis to move forward and conduct a more in-depth assessment. Further assessments should be performed by a licensed or certified clinical professional.

5. What are some of the most common barriers to mental health treatment for veterans?

Correct responses: military culture values strength over weakness (warrior ethos); misinformation about ways treatment can help; mental health stigma in general



### Instructor Note:

Set timer for 10 minutes. When time is up, take five minutes discuss participants’ responses to the quiz questions, and clarify any misunderstandings that arise.



### Answer Key:

Instructor answer key provided above.

## Break

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# Module 4: Navigating Veterans' Resources

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**Time: 2 hours, 10 minutes**

## Module Overview

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A variety of important benefits and services are available to veterans and to their families from the Department of Veterans Affairs and other agencies, but navigating this complex network of resources is a confusing and frustrating experience for many veterans. In Module 4, participants will discover the wide array of resources available to veterans through the federal government and elsewhere. In Lesson 1: Navigating the Department of Veterans Affairs, participants learn about the three branches of the VA – the Veterans Benefits Administration, the Veterans Health Administration, and the National Cemetery Administration. Participants also learn about lesser-known benefits available through the federal VA like family counseling, crisis support hotlines, and funeral services. In Lesson 2, participants become familiar with resources available to veterans outside the federal VA including state departments of veterans affairs, community-based organizations, and the so-called big six veteran service organizations.

### Goals for the Instructor

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- Introduce criminal justice professionals to key information regarding the comprehensive continuum of care provided by the Veterans Health Administration.
- Introduce benefits and resources provided through the Veterans Benefits Administration and the National Cemetery Administration.
- Help criminal justice professionals understand the mechanism for linking veterans to VA care and benefits, particularly understanding the role of the Veterans Justice Outreach specialist.
- Show criminal justice professionals additional resources offered through state departments of Veterans Affairs and county and local veteran-focused entities, including the big six veterans service organizations

### Performance Objectives for Criminal Justice Professionals

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- Distinguish between the benefits-related roles of regional VBA offices versus the care and treatment-related roles of local VHA medical centers and community-based outpatient clinics, called CBOCs.
- Identify the range of VA services available to assist justice-involved veterans.
- Understand the role of the Veterans Justice Outreach specialist as the point of contact for needed treatment resources.

## References, Recommended Reading, and Resources for Veterans



The American Legion: <https://www.legion.org/>  
Department of Veterans Affairs and the Department of Defense: <https://www.ebenefits.va.gov>  
Directory of State Veterans Affairs Offices: <https://www.va.gov/statedva.htm>  
Disabled American Veterans (DAV): <https://www.dav.org/>  
Federal Benefits for Veterans, Dependents and Survivors:  
[https://www.va.gov/opa/publications/benefits\\_book/2016\\_Federal\\_Benefits\\_for\\_Veterans.pdf](https://www.va.gov/opa/publications/benefits_book/2016_Federal_Benefits_for_Veterans.pdf)  
Iraq and Afghanistan Veterans of America: <https://iava.org/>  
Justice for Veterans: <https://justiceforvets.org/>  
National Association of County Veterans Service Officers: <https://www.nacvso.org/>  
National Association of Drug Court Professionals: <http://www.nadcp.org/>  
National Association of State Directors of Veterans Affairs: <http://www.nasdva.us/>  
National Cemetery Administration: <https://www.cem.va.gov/>  
National Coalition for Homeless Veterans: <http://www.nchv.org/>  
Paralyzed Veterans of America: <https://www.pva.org/>  
U.S. Department of Labor Veterans Initiatives: <http://www.veterans.gov/> and  
<https://www.dol.gov/vets/programs/>  
U. S. Department of Veterans Affairs: <https://www.va.gov>  
VA Directory of Veteran and Military Service Organizations: <https://www.va.gov/vso/VSO-Directory.pdf>  
Veterans Benefits Administration (VBA) eBenefits application: <https://www.ebenefits.va.gov>  
by phone: 800-827-1000  
Vet Center Call Center: <https://www.vetcenter.va.gov/> phone: 1-877-WAR VETS  
Veterans Crisis Line Resource Locator:  
<https://www.veteranscrisisline.net/GetHelp/ResourceLocator.aspx>  
Veterans of Foreign Wars: <https://www.vfw.org/>  
Veterans Health Administration: Suicide Prevention 1-800-273-8255, Press 1  
    ○ Visit [www.MilitaryCrisisLine.net](http://www.MilitaryCrisisLine.net) if you are Active-duty, Reserve, or Guard  
    ○ For a confidential online chat session: [www.VeteransCrisisLine.net/chat](http://www.VeteransCrisisLine.net/chat)  
    ○ Text message **838255** to connect to a VA responder  
VA Health Benefits Online resources: <https://www.va.gov/HEALTHBENEFITS/apply/index.asp>  
    ○ By Phone: 1-877-222-VETS (8387)  
Veterans Justice Outreach: <http://www.va.gov/HOMELESS/VJO.asp>  
Veteran Service Organizations: <https://www.va.gov/vso/VSO-Directory.pdf>  
Vietnam Veterans of America: <https://vva.org/>  
Wounded Warrior Project (WWP): <https://www.woundedwarriorproject.org/>

# Lesson 1: Navigating the U.S. Department of Veterans Affairs

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## **Lesson Preview:**

In this lesson, criminal justice professionals will be introduced to the overall structure of the U.S. Department of Veterans Affairs, commonly referred to as the VA. Participants will learn about the three components of the VA – the Veterans Benefits Administration (VBA), the Veterans Health Administration (VHA), and the National Cemetery Administration (NCA). The lesson provides resources and program elements useful to criminal justice professionals when matching veterans to needed services. It also explores the role of Veterans Justice Outreach specialists, or “VJOs,” professionals who serve as conduits to VA services in courts and correctional facilities and in partnership with criminal justice staff.

## **Topics:**

- VA: Mission and Values (10 minutes)
- What is the VA? (5 minutes)
- National Cemetery Administration (10 minutes)
- Overview of the Veterans Benefits Administration (10 minutes)
- Applying for VBA Benefits (5 minutes)
- Homeless Veterans Outreach Coordinators (5 minutes)
- Overview of the Veterans Health Administration (10 minutes)
- Organization of the VHA (5 minutes)
- VHA Services (15 minutes)
- Vet Centers (5 minutes)
- VHA: Homelessness, Housing, and Employment Programs (10 minutes)
- The Veterans Justice Outreach Program (5 minutes)
- VA: Conclusion (5 minutes)

**Total Instruction Time:** 1 hour, 40 minutes

## VA: Missions and Values

Time: 10 minutes

### VA: Mission and Values

**Mission:** *"To care for him who shall have borne the battle, and for his widow, and his orphan."*

-President Abraham Lincoln

"I CARE" core values:

- Integrity, Commitment, Advocacy, Respect, and Excellence

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**Instructor:**

We'll start by talking about the U.S. Department of Veterans Affairs, also referred to as the VA. In this lesson, we will highlight specific resources available to eligible veterans through the VA. All criminal justice professionals working with veterans, not just case managers, should know how to navigate the VA in order to advise and advocate on behalf of veterans for the benefits and services available.



**Ask:**

The VA can serve as a vital resource for supporting justice-involved veterans. What is the role of the VA?

**Anticipated Responses:**

I know about VA home loans; there is a VA medical center in my neighborhood; veterans can get money for school.



**Instructor:**

As you can see, we all have different levels of familiarity with the VA, depending on our own personal and professional experience. The VA's mission is to fulfill President Lincoln's promise, "to care for him who shall have borne the battle, and for his widow, and his orphan" by serving and honoring the men and women who have donned the uniform in defense of the Constitution and our freedoms.

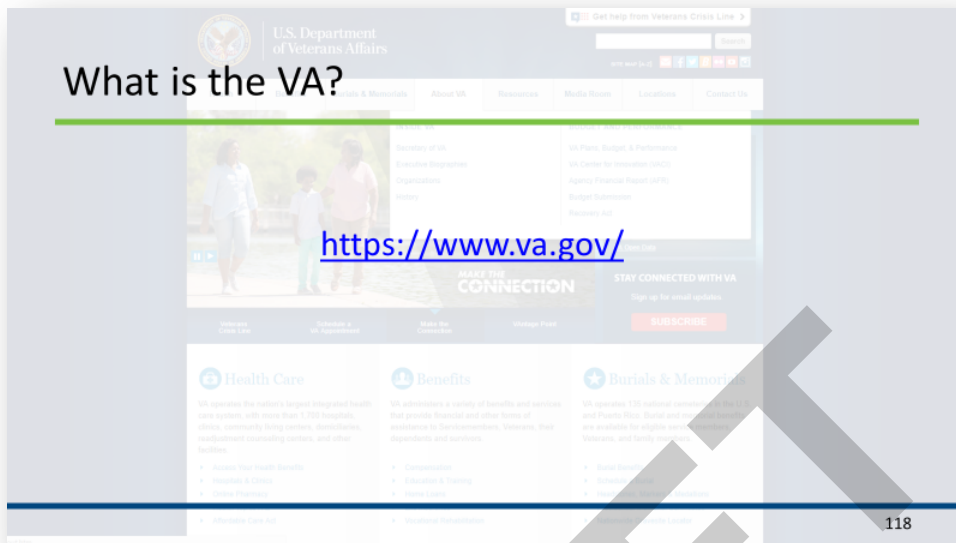
In support of its mission, the VA established its **I CARE Core Values**. These represent the behavioral standards expected of VA employees. "I CARE" is an acronym for **I**ntegrity, **C**ommitment, **A**dvocacy, **R**espect, and **E**xcellence, which the VA emphasizes as the

	foundation of its mission.
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DRAFT

## What is the VA?

Time: 5 minutes



### Instructor Note:

Before instruction begins, display the VA website for participants to view during the discussion of this topic.



### Instructor:

Let's look at the VA's website so you can see how the VA is organized: <https://www.va.gov/>. The VA is a vast organization that has three separate administrative branches. There is the Veterans Benefits Administration (VBA), the Veterans Health Administration (VHA), and the National Cemetery Administration (NCA). They work independently of each other. When referring to these separate entities, people often use the catchall term "VA." In this lesson, we will differentiate between the three, but keep in mind that they are all a part of the larger VA system. Also, keep in mind that as we discussed earlier, not all veterans are eligible for VA healthcare and other benefits. We'll cover all of this shortly.

## National Cemetery Administration (NCA)

Time: 10 minutes

### National Cemetery Administration (NCA)



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#### **Instructor Note:**

Prior to instruction, locate the nearest National Cemetery so that you can refer to it during the below discussion.



#### **Ask:**

We'll start with the National Cemetery Administration, as it's the smallest of the three administrations. Who has been to a National Cemetery?

#### **Anticipated Responses:**

Responses will vary.



#### **Instructor:**

The mission of the National Cemetery Administration—or NCA—is to provide a national shrine and final resting place to honor veterans for their service to the nation. If you have not been to one, the closest in this area is \_\_\_\_\_. Interestingly, Arlington National Cemetery in D.C. is not part of the VA; rather, it is under the auspices of the Army.

The NCA manages 135 national cemeteries, and one national veterans' burial ground, including 33 soldier and monument sites in 41 states and Puerto Rico. Some states don't have a national cemetery. In those cases, states pick up the task of maintaining state cemeteries for veterans.

As of January 2017, the NCA services 3.5 million gravesites, honoring our nation's service members, veterans, and their families. The NCA administers burial benefits for those buried in one of its cemeteries. Burial benefits include opening and closing of the grave, perpetual care, a government headstone or marker, a burial flag, and a Presidential Memorial

Certificate, all at no cost to the family. Some veterans are buried in private cemeteries. In the case of a private cemetery burial, a veteran may be eligible for some of these burial benefits, also at no cost to the family.

If you are working with a justice-involved veteran who has had a recent death in the family, this is an important resource to keep in mind as spouses and eligible dependents may be buried in a national cemetery, which can save a tremendous cost. Eligible dependents include children:

- (1) under 21 years of age;
- (2) under 23 years of age and attending school full-time at an approved educational institution; or
- (3) of any age but became permanently physically or mentally disabled and incapable of self-support before reaching 21 years of age, or before reaching 23 years of age if pursuing a full-time course of instruction at an approved educational institution.

Additionally, adoptive and biological parents of a predeceased former service member are eligible for burial in a national cemetery, under certain limited circumstances. More detailed information is available on the U.S. Department of Veteran Affairs website, which is listed in the References and Resources section of this lesson in your Participant Manual.

# Overview of the Veterans Benefits Administration

Time: 10 minutes

## Veterans Benefits Administration (VBA)

Administers programs that provide financial and other forms of assistance to veterans, their dependents, and survivors.

**Benefits include:**

- Veterans' disability compensation
- Veterans' pension
- Vocational rehabilitation and employment assistance
- eBenefits Employment Center
- GI Bill education assistance
- Dependents' education assistance
- Home loans
- Life insurance

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**Instructor Note:**

This section will cover the range of benefits under the Veterans Benefits Administration, as distinct from the Veterans Health Administration. The Veterans Health Administration is a provider of health care and will be the focus of the next section.



**Instructor:**

The role of the Veterans Benefits Administration—or VBA—is to determine eligibility for services, process benefit applications, and disburse funds. The benefits offered by the VBA are veterans' disability compensation and pension, vocational and employment assistance, GI Bill education assistance, the eBenefits employment center directory, home loans, life insurance, and certain survivors' benefits. The VBA has 58 regional offices: 56 throughout the United States, one in Puerto Rico, and one in the Philippines.

## Veterans Benefits Administration (VBA)

Administers programs that provide financial and other forms of assistance to veterans, their dependents, and survivors.

**Eligibility criteria includes:**

- Length of service
- Wartime or peacetime service
- Disability connected to service
- Discharge status
- Income
- Age

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**Instructor:**

VBA benefits can have a tremendously powerful impact on a veteran's financial stability, ability to pursue higher education or training, or the opportunity to find and keep a good job. These are critical pieces of the puzzle when a veteran is reintegrating into civilian life. Because these benefits can stabilize and reshape his or her future, it's important that criminal justice professionals who encounter justice-involved veterans understand the basics of VBA eligibility criteria. Even though we may not be able to determine if a veteran is eligible, it's important to consider factors that may impact eligibility that might be changeable, such as discharge status, which can sometimes be upgraded by completing and filing a DD Form 293, *Application for the Review of Discharge or Dismissal from the Armed Forces of the United States*.

Many factors influence a veteran's eligibility for benefits including income, age, length of service, whether service was in wartime or peacetime, if a disability results from that service, and discharge status.

Additional information and specific eligibility criteria for each benefit is available on the VA website. In general, it is good practice to encourage or assist veterans to apply for VBA benefits, even if it might seem like they do not meet some criteria.

## VBA: Applying for Benefits

Time: 5 minutes

### VBA: Applying for Benefits

- In person: nearest regional office, medical center, or community-based outpatient clinic
- Online: <https://www.ebenefits.va.gov>
- By phone: 1-800-827-1000 (VBA National Call Center)
- Through an accredited Veterans Service Organization (VSO) representative, attorney, or claims agent
- VA Office of General Counsel's list of accredited reps: <http://www.va.gov/ogc/apps/accreditation/index.asp>

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#### **Instructor:**

There are several ways criminal justice professionals can support, refer, or encourage veterans to apply for benefits.

A veteran can apply in person at the nearest regional office or VA medical center; online—using the eBenefits application, or via phone. Whatever method a veteran uses, it is recommended that they work with an accredited veterans service organization (VSO), county service representative, attorney, or claims agent. Accredited VSO representatives have undergone training and certification and tend to have a great deal of experience with the application process—they know how to dot the i's and cross the t's. The Veteran Affairs' Office of General Counsel maintains a list of accredited representatives on its website. The contact information for this resource, and the others mentioned in this lesson, can be found on in the References and Resources section of this lesson in your Participant Manual.

# Homeless Veterans Outreach Coordinators

Time: 5 minutes

## Homeless Veterans Outreach Coordinators (HVOC)

- At least one HVOC at every VBA regional office
- Outreach to homeless veterans at shelters, stand downs, through state and local community partners and other areas
- Process claims for homeless veterans and those at risk of becoming homeless to ensure they are expedited
- Outreach to justice-involved veterans in VTCs, prisons, and jails
- Outreach includes providing information and assistance on VA benefits and services and assisting with filing claims

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### Instructor:

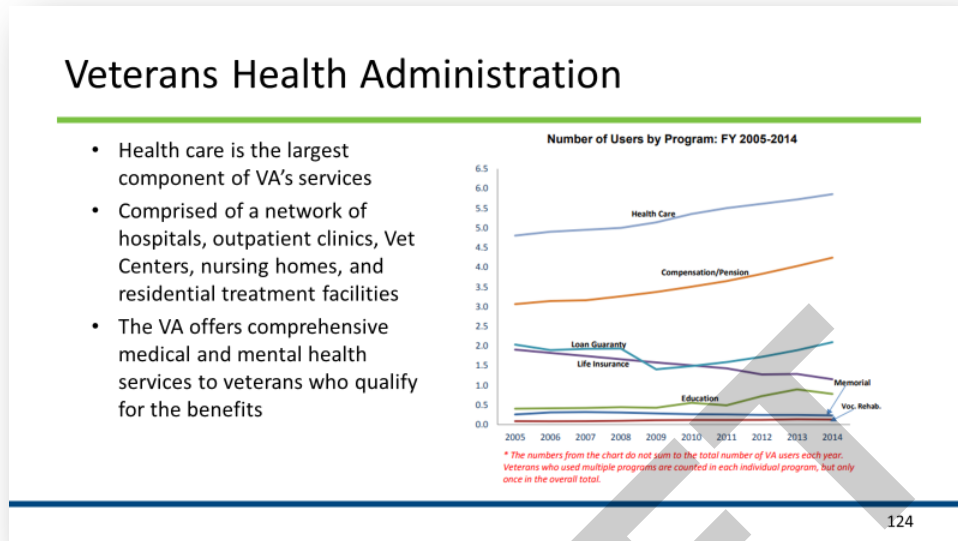
Approximately eleven percent of the homeless adult population (and 20 percent of the homeless adult, male population) are veterans. 1.4 million more veterans meanwhile, are at risk of homelessness due to poverty, lack of support networks, and substandard living conditions.

The VA is committed to ending veteran homelessness in several ways. One strategy is by having a Homeless Veterans Outreach Coordinator (HVOC) at each one of its VBA regional offices. HVOCs specialize in assisting homeless and incarcerated veterans with accessing VBA benefits. HVOCs are responsible for outreach to homeless veterans at various locations including shelters, stand downs (which are local community events aimed to support homeless veterans), and community partner events. If you are working with a justice-involved veteran at risk for homelessness, contact your local VBA regional office to connect with an HVOC.

Another important resource to be aware of is the Health Care for Re-entry Veterans (HCRV) specialist under the VHA, which will be discussed later in the lessons. The HCRV specialist is primarily a social worker who completes a clinical assessment and links a veteran to comprehensive services after release from prison. The HVOC's and HCRV specialist roles are different although their responsibilities may overlap.

# Overview of the Veterans Health Administration

Time: 10 minutes



### Ask:

We spoke earlier about the three different branches of the VA. What do you think is the difference between the Veterans Benefits Administration and the Veterans Health Administration?

### Anticipated Responses:

VBA is for benefits and VHA is for medical care.



### Instructor:

Great, now we're going to talk more about the Veterans Health Administration.

The Veterans Health Administration—or VHA—has 1,245 healthcare facilities including 170 medical centers and 1,065 outpatient sites. Together, these sites serve nearly 7 million of the more than 9 million veterans registered with the VHA each year.

Healthcare is the largest component of the VA's services. The VHA offers comprehensive medical and mental health services to veterans who qualify for medical benefits and can access these benefits and services. It is comprised of a network of hospitals, outpatient clinics, Vet Centers, nursing homes, and residential treatment facilities. The Vet Centers—there are 300 of them—are the only facet of the VHA that works with military families as well as the veterans themselves. Approximately 80% of those who serve in the military are eligible to receive VBA benefits and VHA healthcare.

As you can see from the table, the number of veterans using VHA healthcare facilities is consistently higher than any other VA service. The next largest type of service accessed is

compensation and pensions, which as we learned, is provided by the VBA.

If you are aware of a justice-involved veteran in need of healthcare, you should refer them the VA's website or phone number to apply for VHA health benefits. For more information, see the References, Recommended Reading, and Veteran Resources section at the beginning of the module.

DRAFT

## Veterans Health Administration

- Limits to health benefits authorization for justice-involved veterans:
  - VHA cannot accept custody of a veteran or offer locked residential treatment – VHA treatment is voluntary
  - VHA is barred by law from providing medical benefits while a veteran is incarcerated [38 CFR 17.38 (c)(5)]

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### Instructor Note:

You should mention statute 38 CFR 17.38 (c)(5). Refer participants to a copy of the statute on page 36 of the Participant Manual.



### Instructor:

There are two important treatment-related considerations that criminal justice professionals should be aware of when working with justice-involved veterans. The first is that the VA cannot take custody over an individual or ensure that they remain in residential or inpatient treatment because all participation in VHA healthcare is voluntary. The second consideration is that federal statute prohibits VHA medical benefits for incarcerated veterans. There's a copy of the relevant statute in your Participant Manual on page 36.

However, these restrictions do not preclude the extensive outreach the VA conducts in jails and prisons through HVOCs and other program staff. Keep in mind that in order for criminal justice professionals to disclose information to the HVOC or other staff, there must be a release of information form signed by the veteran to allow information sharing between the parties.

# Organization of the VHA

Time: 5 minutes

## Organization of the VHA

- Regional: organized into 18 Veterans Integrated Service Networks (VISNs)

Where is the nearest medical center or other health care facility?

Use the facility [locator](#) to find VA medical facilities



### Instructor Note:

Before teaching this segment, please look at this link to locate the closest VHA facility to use as an example:

<http://www.va.gov/directory/guide/division.asp?dnum=1>

Participants may notice that some numbers are missing from the map. The VA consolidated VISNs so the current sequence begins with the number 1 and ends with 23. VISN 3, 11, 13, 14 and 18 no longer exist.



### Ask:

Who has been to a VA Medical Center?

### Anticipated Responses:

Responses will vary.

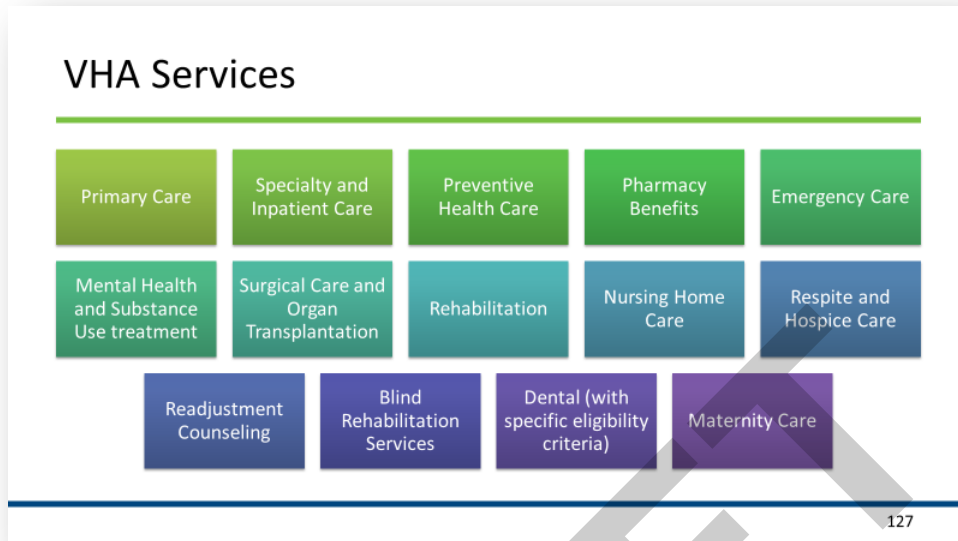


### Instructor:

The closest VA Medical Center is \_\_\_\_\_. VA Medical Centers are a part of a large geographical network of VHA healthcare services, known as Veterans Integrated Service Networks, or VISNs. As of 2017, across the country, there are 18 VISNs, most of which are comprised of several different states. Each regional network typically includes VISN administrative offices, Vet Centers, healthcare systems, medical centers, domiciliary care programs, and community-based outpatient clinics (CBOCs).

## VHA Services

Time: 15 minutes



**Instructor:**

As you can see on the slide, VHA's healthcare services are comprehensive and include primary care, readjustment counseling, prescription benefits, mental health and substance use treatment, respite and hospice care, and much more.



**Ask:**

Which services do you think are most relevant for the justice-involved population?

**Anticipated Responses:**

Substance use; mental health treatment



**Instructor Note:**

Below, you will elaborate on the responses with information about the most relevant VHA services for justice-involved veterans.



**Instructor:**

That's right. In Module 3, we learned about the connection between justice-involved veterans and substance use disorders.

Treatment services offered by the VHA vary by medical center. The VHA's substance use disorder treatment continuum provides an array of services to clinically suit each veteran's indicated level of care. This typically includes detox, residential, outpatient, aftercare, and a range of MAT—medication for addiction treatment (formerly referred to as medication-assisted treatment).

Also, as you learned in Module 3, mental health issues are common among justice-involved

veterans. The VHA's mental health treatment continuum was developed to respond to a series of veterans' issues ranging from adjustment disorder, generalized anxiety disorder, major depression, as well as the unique issues surrounding combat-related PTSD, military sexual trauma, and the mental health-related impact associated with traumatic brain and spinal cord injury.

The VHA will assess, diagnose, and treat along the continuum of care and offer evidence-based treatment in various settings. Services are available to veterans in inpatient, outpatient, and residential settings. These recovery-oriented services are self-directed, individualized, strengths-based, and include peer support components.

Case managers working in courts should refer justice-involved veterans to a VHA specialist for mental health treatment, where eligible. Justice-involved veterans who are not incarcerated are eligible for treatment on the same basis as other veterans; generally, a veteran's discharge must be under conditions other than dishonorable (e.g. honorable, under honorable conditions, general). However, individuals receiving undesirable, bad conduct, and other types of dishonorable discharges may qualify for mental health depending on a determination made by VA.

It is VHA policy that eligible, justice-involved veterans must have access to VHA mental health services when clinically indicated.

## VHA: Suicide Prevention Efforts

- Dial **1-800-273-8255** and **press 1** to talk to a clinician trained in suicide prevention
- Start a confidential online chat session at: [www.VeteransCrisisLine.net/chat](http://www.VeteransCrisisLine.net/chat)
- Send a text message to **838255** to connect to a VA responder
- Take a self-check quiz at [www.VeteransCrisisLine.net/quiz](http://www.VeteransCrisisLine.net/quiz)
- If you or a veteran you know is in crisis, [find a facility](#) near you
- Visit [www.MilitaryCrisisLine.net](http://www.MilitaryCrisisLine.net) if you are active duty, reserve, or guard
- Additional information:  
[https://www.mentalhealth.va.gov/MENTALHEALTH/suicide\\_prevention/index.asp](https://www.mentalhealth.va.gov/MENTALHEALTH/suicide_prevention/index.asp)

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### Instructor Note:

The VA website has a lot of information regarding veterans' suicide prevention. Please note the webpage for veterans is different than the webpage for active-duty service members.



### Instructor:

Addressing veteran suicide is another priority of the VA, and is an effort that involves both the VHA and the community. The VHA has increased resources to prevent veteran suicide by actively engaging families, friends, and raising community awareness. For example, there is a suicide prevention coordinator at every VA medical center in the U.S.

There are some misconceptions about veterans who commit suicide, e.g., that veterans who experience combat or are younger commit suicide at a higher rate. In reality, veteran suicide spans demographic area and conflict era. And in fact, as we learned earlier, research has shown that older veterans are at particularly high risk for suicide and are more likely to use a firearm. It is important to educate friends, family, and the community about firearms safety, suicide prevention, and treatment that will help save lives.

The Veterans Crisis Line is available for veterans and family members, regardless of VA benefits eligibility. The Veterans Crisis Line website hosts resources for veterans, providers, and family members. Individuals can learn the warning signs of suicide, take a suicide assessment quiz, and find local resources.

The Veterans Crisis Line has a toll-free number (1-800-273-8255), a web chat ([veteranscrisisline.net/chat](http://veteranscrisisline.net/chat)), text messaging (838255) to connect to a VA responder. Also, there's a separate website available for active-duty, reserve, and National Guard members ([www.militarycrisisline.net](http://www.militarycrisisline.net)).

## Vet Centers

Time: 5 minutes

### Vet Centers

- Eligibility: veteran (or family member) served in active duty in any combat theater or area of hostility or experienced military sexual trauma
- Readjustment counseling service for veterans and their families

Screening and referral for medical issues	Outreach and education at community events	Family counseling for military-related issues
Individual and group counseling	Bereavement counseling for families who experience an active duty death	Military sexual trauma referral and counseling
Employment assessment and referral	Substance use assessment and referral	VBA benefits explanation and referral

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### Instructor:

Vet Centers are stand-alone locations. Although they operate under the VHA, they are separate entities. Vet Centers are specifically designed to provide services for veterans who served on active-duty in any combat theater or area of hostility or experienced military sexual trauma, and their families. As we know, the transition from combat to civilian life can be difficult and can require specialized services. The services provided are wide-ranging and can be used independently of, or in conjunction with, other VHA services.

Vet Centers can be a valuable partner for a court or jail program since they offer additional resources and separate eligibility criteria from the VHA and VBA.

Other Vet Center resources include Mobile Vet Centers (MVCs), which are available across the country, and the Vet Center Call Center's confidential 800 number, at which specialists are available around the clock to talk to veterans about their military experience as well as any other readjustment issues they're facing.

# VHA Homelessness, Housing, and Employment Programs

Time: 10 minutes

## Housing & Employment

### Housing and Homelessness:

- One of VA's key priorities is ending veteran homelessness
- VA is the largest single provider of homeless services in the nation
- VA offers a range of interventions designed to locate homeless veterans, engage them in services, find pathways to permanent housing, and prevent homelessness

### Employment

- VA: Therapeutic Supported Employment Services/Compensated Work Therapy

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### Instructor Note:

Homelessness was discussed earlier under the VBA section, which focused on VBA staff and their role in providing HVOCs. This section discusses homelessness, housing, and employment programs offered by the VHA. Acknowledge the overlap in services as it arises.



### Ask:

How many homeless veterans do you think there are in the U.S.?

### Anticipated Responses:

30 - 50,000 veterans



### Instructor:

A 2016 report from the U.S. Department of Housing and Urban Development found that there were approximately 40,000 homeless veterans, but that the numbers have been declining since 2010.

When a homeless, unemployed, or underemployed veteran comes to the VHA for medical care, other services and benefits will be addressed.

The VA has prioritized the reduction of homelessness with the goal of providing access to safe, affordable, and permanent housing for all veterans in need. The VA is the nation's largest provider of homeless services, with a wide array of interventions designed to locate homeless veterans, prevent homelessness, engage veterans in services, and help them

secure permanent housing. Every VA medical center offers a range of specialized services for homeless veterans.

The VHA has the same commitment as the VBA to reducing homelessness albeit from a medical perspective. Since the focus of the VHA is to provide holistic medical care, homelessness, housing, and employment are treated along with a veteran's physical and mental health needs.

VA medical centers provide an opportunity to reach veterans in need of employment. Several programs are available, such as Therapeutic Supported Employment Services, Compensated Work Therapy, and Homeless Veterans' Community Employment Services. These programs help veterans deal with barriers to employment, develop vocational and educational skills, and match with appropriate employers. The VA has partnered with the U.S. Department of Labor to support this mission.

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## VHA: Healthcare for Re-entry Veterans (HCRV)

- Justice-involved veterans are more likely to be homeless
- HCRV's mission is to prevent homelessness and promote success for veterans after incarceration
- HCRV services include:
  - Outreach and pre-release assessment services for veterans in prison
  - Referrals and linkages to medical, mental health, and social services, including employment services on release

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### **Instructor Note:**

Justice-involved veterans may be eligible for VA benefits. A justice-involved veteran currently receiving benefits might need assistance understanding if those benefits can continue and what services are available for reintegration. For more information, visit: <https://www.va.gov/homeless/reentry.asp>.



### **Instructor:**

Most veterans who are in jail or prison will eventually reenter our communities. Justice-involved veterans are more likely to end up homeless than non-justice-involved veterans, which may perpetuate the cycle of involvement in the criminal justice system. To address this concern, the VA's Healthcare for Re-entry Veterans program (HCRV) is designed to promote successful reintegration and prevent homelessness among veterans after release from jail or prison. HCRV specialists are primarily social workers who engage with incarcerated or recently incarcerated veterans to complete a clinical assessment and link them to comprehensive services after release.

HCRV services include outreach and pre-release assessments for veterans in prison, medical, mental health, social services, and employment service referrals upon release, and short-term case management.

## Veterans Justice Outreach Program

Time: 5 minutes

### Serving Justice-Involved Veterans

Veterans Justice Outreach Program (interfacing with veterans at the front end of justice system)

- Jail outreach and associated eligibility determination, assessment, and treatment linkage
- Liaising with VA and community law enforcement
- Liaising with court system and staffing of collaborative treatment courts
- Short-term case management as indicated
- Linkage to ancillary support (e.g., child support services, legal assistance)

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#### **Instructor:**

Another key VA strategy for serving justice-involved veterans is the Veterans Justice Outreach Program. Veterans Justice Outreach specialists (VJOs) perform many functions, like assisting with clinical assessments, offering direct case management services, providing evidence-based treatment for court-monitored veterans, and making referrals to comprehensive health care services. VJOs serve as a liaison between the VA and the court system and or the veteran's lawyer (with the veteran's consent). In jurisdictions with a veterans treatment court, the VJO might serve as an active member of the court team, attending staffing meetings and court sessions.

Level of service varies by jurisdiction. Some VJO's have very large catchment areas and unfortunately can't provide the level of hands-on service that others can. You should check with the VA to see what services are available through your nearest VJO. If there isn't one nearby you, the VA might even be able to assign one for your jurisdiction—so reach out!



#### **Ask:**

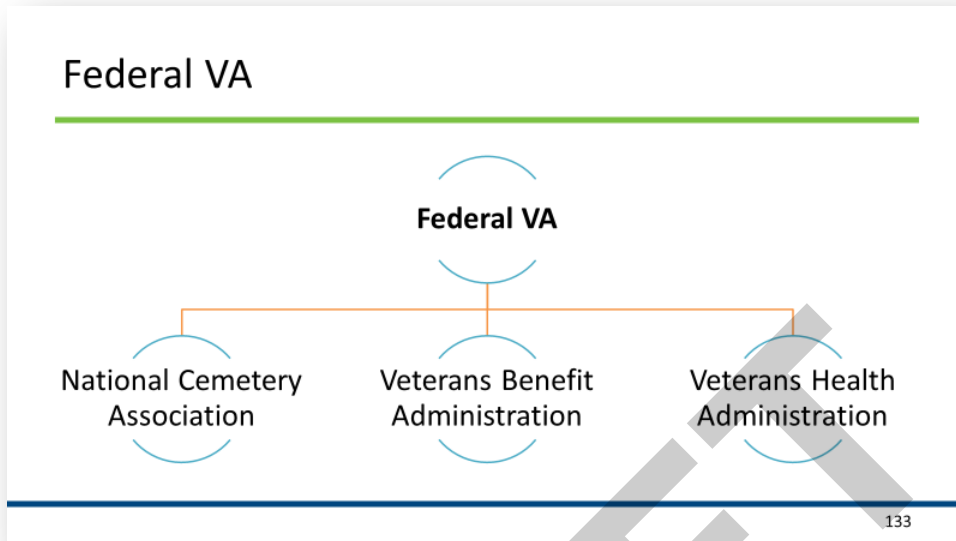
Have you worked with a VJO or an HCRV? If so, how were they able to help you or your client?

#### ***Anticipated Response:***

Responses will vary.

## VA: Conclusion

Time: 5 minutes



**Instructor:**

Let's take a minute to review what we've covered. There are three branches of the federal VA, the National Cemetery Administration, Veterans Benefits Administration, and the Veterans Health Administration. They provide comprehensive resources for eligible veterans, including a vast array of services, which can seem intimidating, but keep in mind your local VA should be able to help and the VA website has a lot of information available. We'll now take a break and then we'll start our next lesson on other resources that are available for veterans outside of the VA.

## Lunch Break

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## Lesson 2: Other Veterans' Resources

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### **Lesson Preview:**

In this lesson, participants will learn about resources outside the federal VA, including state departments of Veterans Affairs, community-based/non-profit organizations, and the so-called Big Six veteran service organizations.

### **Topics:**

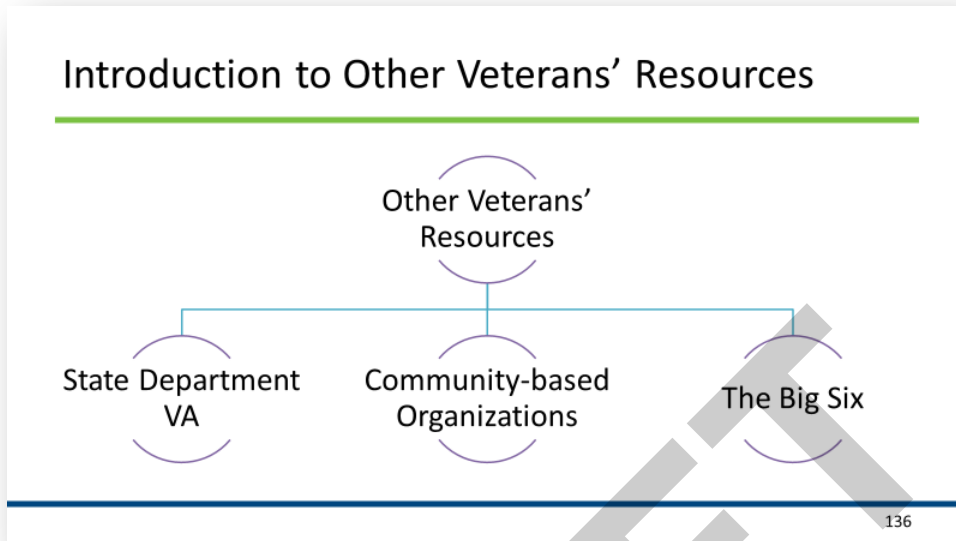
- Introduction to other Veterans' Resources (5 minutes)
- State Departments of Veterans Affairs (5 minutes)
- Community-Based/Non-Profit Organizations (5 minutes)
- The Big Six Veterans Service Organizations (10 minutes)
- Conclusion (5 minutes)

**Total Instruction Time:** 30 minutes

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## Introduction to Other Veterans Resources

Time: 5 minutes



**Instructor:**

In this lesson, we'll learn about resources other than the federal VA that are available to veterans. These resources are important to know about because, as we discussed, not all veterans are able to access the benefits and healthcare of the federal VA because of barriers such as eligibility or location. Additionally, some veterans might prefer to tap into other resources because of their personal preferences. We'll learn about state department VA offices, community-based organizations, and the so-called big six veteran service organizations.

## State Departments of Veterans Affairs

Time: 5 minutes

### State Departments of Veterans Affairs

State funded agencies that handle state and local resources for veterans statewide. Many have multi-million-dollar annual state budgets and oversee:

- Veterans benefits and claims, including overseeing County Veteran Service Officers.
- State Veterans Homes: provide skilled nursing, domiciliary, and/or adult day care.
- State Veterans Cemeteries
- Assistance with: special programs/populations (e.g. homeless, women, employment, education); state interagency programs and partnerships
- State grants or budget line items to support VTCs
- Jail and prison outreach by state service officers; state level task forces including justice partners; mentors recruit/train

Locate a State DVA: <https://www.va.gov/statedva.htm>

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#### Instructor:

State departments of veterans affairs can be key partners in obtaining services—including federal benefits—for veterans. States have large budgets to oversee veterans benefits claims, to provide medical treatment, housing, and adult care, as well as caring for state veterans' cemeteries and assisting with special programming like homelessness, employment, and education.

An example of the federal and state partnership is that states often have grant programs or budgeted funding to support veteran treatment courts and jail and prison outreach programs. The state and federal VA partner with state service officers and state level task forces for training, mentoring, and justice partnerships.

Additionally, state VAs employ and oversee County Veterans Service Officers (CVSO) who are tasked with knowing their way around the federal VA and assisting veterans and their families in navigating these systems.

## Community-Based/Non-Profit Organizations

Time: 5 minutes

### Community-based/Non-profit Organizations

- Thousands throughout U.S.
- Several types of focuses
- City- and state-based initiatives
- Colleges and universities
- Charities/foundations
- Non-profit organizations
- Faith-based groups

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#### Instructor:

There are close to 50,000 organizations in the United States devoted to helping veterans and their families. While some are city or state-based initiatives, such as mayor's office agencies or state VAs, others are private foundations, university-based initiatives, and non-profit and/or faith-based organizations. With such a large number of organizations, it's important for practitioners to be familiar with the organizations active in their area and to be informed about which ones provide quality services.

The areas of focus that each organization covers are widespread and include housing support (such as the Fisher House Foundation), support for surviving family members of servicemembers (such as TAPS), the Tragedy Assistance Program for Survivors (which does advocacy work), and investment in research and education (like the Bob Woodruff Foundation).

These organizations are crucial to helping support veterans and their families, so be sure to familiarize yourself and build partnerships with your local military and veterans organizations.

# The Big Six Veterans Service Organizations

Time: 5 minutes

## The Big Six Veterans Service Organizations

- Disabled American Veterans (DAV)
- Veterans of Foreign Wars (VFW)
- American Legion
- Paralyzed Veterans of America (PVA)
- AMVETS
- Vietnam Veterans of America (VVA)

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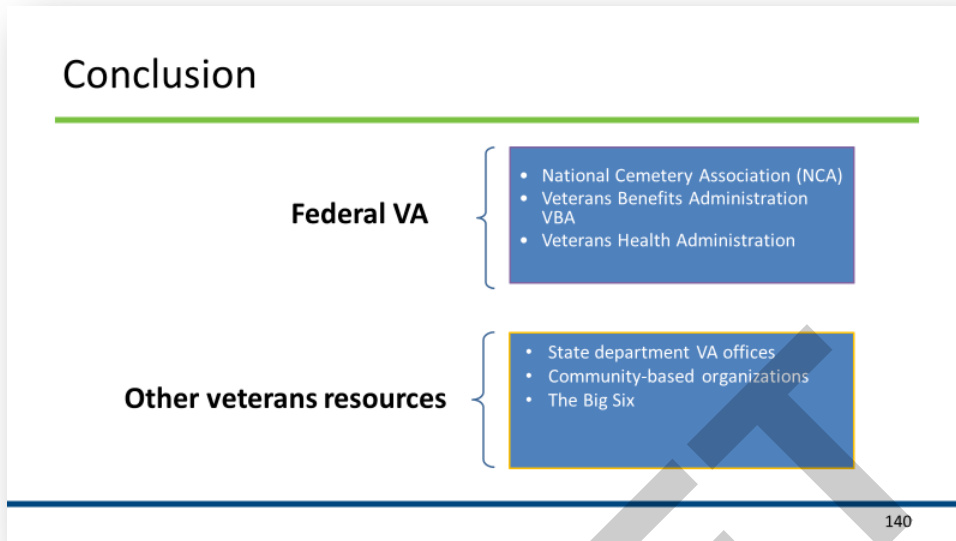


### **Instructor:**

Another group of organizations that are integral to the support of veterans are the “Big Six Veterans Service Organizations.” The Big Six consists of: Disabled American Veterans (DAV), Veterans of Foreign Wars (VFW), American Legion, Paralyzed Veterans of America (PVA), AMVETS, and Vietnam Veterans of America (VVA). These organizations provide crucial support to veterans across the United States and are often called upon by Congress to provide information about the state of veterans affairs. The VA keeps a directory of contact information for all veterans service organizations on their website.

## Conclusion

Time: 5 minutes



### Instructor:

We've reached the end of Module 4. Now that you have a better sense of the resources and services available to veterans, you should feel confident in your ability to connect the veterans you work with to the resources best-equipped to assist them. In Lesson 1, we discussed the three branches of the federal VA—the National Cemetery Administration, Veterans Benefits Administration, and the Veterans Health Administration. Each branch provides a number of services and benefits to eligible veterans. Remember that your local VA should be able to help you navigate the services provided by each branch, and the VA website has a lot of information available.

In Lesson 2, we discussed resources outside the federal VA that are available to veterans. It is crucial to be aware of these resources because, as you now know, not all veterans are able to access the benefits and healthcare of the federal VA. In addition, some veterans may prefer not to seek assistance from the VA. In either case, state department VA offices, community-based organizations, and the so-called Big Six veteran service organizations are alternative sources of assistance for veterans.

## Module 4 Quiz

Time: 10 minutes

**Directions:** Select the best answer to the following multiple choice-questions about the veterans' resources discussed in Module 4.



1. Which one of the following is not a primary branch of the Department of Veterans Affairs?
  - a. National Cemetery Association
  - b. Veterans Benefit Administration
  - ☒ c. Veterans' Affairs Office of General Counsel
  - d. Veterans Health Administration
2. Which one of the following statement(s) correctly describes the limits on services provided to justice-involved veterans through the Veterans Health Administration (VHA)?
  - ☒ a. Incarcerated veterans cannot access VHA medical benefits for the duration of their incarceration.
  - b. All justice-involved veterans have access to healthcare through the VHA.
  - c. **A veteran may be able to retain VHA health care while incarcerated, if (s)he was discharged under honorable conditions.**
  - d. **Veterans convicted of a felony offense will become permanently ineligible for VHA healthcare.**
3. Which one of the following is not a factor in determining eligibility for VBA benefits?
  - a. Age
  - b. Income
  - c. Discharge status
  - ☒ d. Marital status
4. What is the role of a County Veterans Service Officer (CVSO)?
  - a. A CVSO administers assessments to identify the veterans' healthcare needs.
  - ☒ b. A CVSO provides guidance to veterans and their families related to the benefits available from federal, state, and county resources.
  - c. A CVSO reviews veterans' benefits applications and makes decisions related to benefits eligibility.
  - d. A CVSO oversees veteran treatment courts and jail/prison outreach programs.
5. If you are working with a veteran struggling to find stable housing, which of the following resources would likely be most useful?
  - a. A County Veterans Service Officer
  - ☒ b. A Homeless Veterans Outreach Coordinator (HVOC)
  - c. A Veterans Service Organization representative
  - d. Your local VHA healthcare facility.



**Instructor:**

You'll now take a brief quiz to assess your understanding of the resources we covered in Module 4.

You'll have 10 minutes to complete the quiz and then we will review the answers. After reviewing the answers, we'll take a break before beginning Module 5.

	<p><b>Instructor Note:</b></p> <p>Ask participants to open their Participant Manual to page 38. Allow them 10 minutes to complete the quiz.</p>
	<p><b>Answer Key:</b></p> <p>After participants have completed the quiz, review the correct answers using the answer key above.</p>

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## Break

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# Module 5: Responsivity and Justice-Involved Veterans

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**Time: 4 hours, 5 minutes**

## Module Overview

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In Lesson 1: Case Management, participants receive an overview of case management, including the functions and tasks of the case manager, and discover how case management can improve outcomes for justice-involved veterans. In Lesson 2: Responsivity in the Criminal Justice System, participants discuss several aspects of responsivity in the criminal justice system: veterans treatment courts, procedural justice, domestic violence issues, and corrections-based programming for veterans. Lesson 2 also introduces the sequential intercept model for justice-involved veterans and explains how this model can help practitioners identify opportunities for linkage to services, and prevent further involvement in the criminal justice system.

### Goals for the Instructor

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- Introduce criminal justice professionals to case management principles and models
- Increase criminal justice professionals' understanding of the role of a case manager
- Provide criminal justice professionals with case management tools that can be used when working with justice-involved veterans
- Introduce criminal justice professionals to veterans treatment courts and their operating structure
- Introduce participants to the theory and practical applications of procedural justice
- Facilitate an understanding of domestic violence issues as they relate to veterans
- Teach participants about correctional institution-based programs for veterans

### Performance Objectives for Participants

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- Identify case management principles and case management models
- Understand the role of a case manager in improving outcomes for justice-involved veterans
- Incorporate case management skills that can be used in the criminal justice arena
- Understand the operating structure of veterans treatment courts
- Be able to identify practical applications of procedural justice
- Establish a foundation regarding domestic violence in the veteran population
- Recognize the presence of correctional institution-based programs for veterans

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## Lesson 1: Case Management

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### Lesson Overview:

In the criminal justice system, justice-involved veterans might work with staff who apply case management tools or perform the role of a case manager. A case manager can be pivotal in assisting a veteran in obtaining benefits and providing that veteran with services and information that is not readily accessible. In this lesson, participants will receive an overview of the functions and tasks of case management and discover how case management can improve outcomes for justice-involved veterans.

### Topics:

- Needs Assessment (20 minutes)
- Role of the Case Manager (5 minutes)
- Case Management Functions and Tasks (5 minutes)
- Case Management Principles (25 minutes)
- Case Planning (10 minutes)
- SMART Case Plans (10 minutes)
- Skills Building: Case Study (30 minutes)

**Total Instruction Time:** 1 hour, 15 minutes

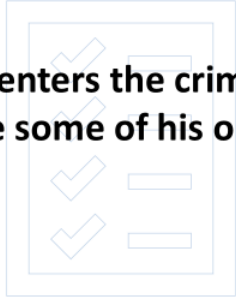
## Needs Assessment

Time: 20 minutes

### Needs Assessment

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**When a veteran enters the criminal justice system, what are some of his or her needs?**



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**Instructor:**

Welcome back. You'll remember that we learned about the theory of "responsivity" in Module 2. Today, we're going to take a deeper dive into how we provide services for our veterans. In this module, you might feel like the topics are more diverse than in previous modules, but stick with me! The first lesson is about case management. The purpose of this lesson is to help you understand the role of case management when working with justice-involved veterans and to expose you to the models, functions, and principles of case management.



**Ask:**

When a veteran enters the criminal justice system, what potential support and service needs might he or she require?

***Anticipated Responses:***

Homelessness; employment (financially struggling); family problems; substance use issues; mental health issues; medical injury



**Flipchart:**

Use a flipchart to keep track of the list. Once you have completed the list, place it on a wall in an area visible to the participants.



**Instructor:**

This is a great list. Justice-involved veterans face a plethora of needs throughout their involvement with the criminal justice system.

Justice-involved veterans have unique challenges as well as access to unique resources that are not available to non-veteran justice-involved individuals. You'll remember from the last module the extensive amount of resources available to that former service members.

This list we created represents the gamut of needs that those working with veterans will typically screen and assess for. But remember, as we discussed earlier, we shouldn't screen or assess for things like mental health, substance use, or risk based on a gut feeling, previous experiences, or clinical subjectivity alone. Veterans should be screened and assessed using research-based tools. When using subjectivity to determine needs, one may end up doing more harm than good.

Once we've determined a person's needs through the use of tools and other evaluations, what do we do with this information and what are best practices for managing these needs?

Typically, that responsibility falls on a case manager. Generally, a case manager is the person conducting assessments at various points in the criminal justice process. We will learn more about their role now.

## Role of the Case Manager

Time: 5 minutes

### Role of the Case Manager

- In the criminal justice system, a case manager is responsible for bridging the gap between a client's needs and the services required to address those needs.



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#### Ask:

So, what role does a case manager play in your court or agency?

#### **Anticipated Responses:**

Case managers make referrals; we don't have case managers in our court



#### Instructor:

As demonstrated by your answers, the role of a case manager in the criminal justice system can vary depending on the court or agency. Case managers' functions and tasks are multifaceted. One constant is that all case managers advocate for their clients and model pro-social attitudes and behaviors through healthy communication practices and problem-solving techniques.

In the criminal justice system, case managers work with justice-involved veterans in jails, prisons, and treatment courts. The VA and other organizations that support veterans also employ case managers to work with veterans who are eligible for their services.

A case manager working with veterans in the criminal justice system is typically responsible for conducting needs assessments, knowing how to navigate the benefits and resources of the VA, and making referrals to appropriate services. In sum, it is a case manager's job to bridge the gap between a veteran's needs and the services required to address those needs.

## Case Management Functions and Tasks

Time: 5 minutes



### Instructor:

A case manager is usually responsible for any combination of assessing, planning, linking, monitoring, and advocating for their clients. Let's discuss what we mean by each of these functions.

To determine the initial needs of a veteran, an **assessment** is conducted by a case manager. The assessment contains a mixture of determinants to identify a veteran's needs. The assessment can include a bio-psychosocial component, a risk-needs assessment, a clinical assessment, and inquiries to determine a veteran's desires, strengths, and resources. The **assessment** will provide the necessary information to develop an appropriate case plan.

**Planning** involves defining the goals for the veteran to achieve. Planning also involves developing strategies for each goal, identifying action steps, determining who is responsible for each step, and working out a timeframe. A well-defined plan provides structure and guidelines. The case plan continually evolves as the veteran evolves. As the veteran addresses his or her needs, or encounters new challenges, the case manager should modify the plan in step.

A case manager must be able to **link** a veteran to appropriate services that adequately address and support his or her goals. The success of the case plan is contingent upon the proper linkages being established.

Once the linkages and referrals are made, the case manager **monitors** the veteran's ability to achieve goals by engaging with service providers to ensure client participation and

service practicality, by identifying and addressing barriers that prevent success, and by modifying the case plan when needed.

And **advocacy** is the case manager's active support to provide a veteran with access to eligible services. It goes beyond just making a referral. There are times when a case manager can and should actively lobby on behalf of their client for services. This type of advocacy can make a difference in a veteran's ability to access resources.

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# Case Management Principles

Time: 25 minutes



## Instructor Note:

In this section, divide the participants into small groups. The participant groups will match the definitions with principles and examples in their Participant Manuals. During the discussion, encourage participants to share their own examples.



## Instructor:

Case managers who work with justice-involved individuals not only have to be advocates for their clients, they must also work to protect the safety of the public. What some see as divergent concerns, criminal justice case managers deal with seamlessly using these 12 principles.



## Activity:

We're going to do an exercise with these principles. On page 44 of your Participant Manual, you will find a list of the principles, as well as their definitions and an example of each. You'll have ten minutes in your small group to match each principle with its definition and example. Then you'll share your answers with the whole group.



## Instructor Note:

Once the groups are done, use the answer key on the following page to have a conversation about their responses. Let participants volunteer their answers. Prompt them to come up with examples.



**Answer Key:**

Principle	Definition	Example
Evidence-based: L 5	i. Case management utilizes methodology that is rigorously tested through research and practice.	5. Using a validated risk-need assessment tool to inform case planning.
Strengths-based: C 9	c. Case management should leverage the strengths, skills, and existing resources of a client to enhance and promote the recovery process.	9. Helping a veteran get a job using the skills that he or she acquired in the military.
Relationship-based: J 12	j. The relationship between case manager and client is built on mutual respect, honesty, and trust. The case manager collaborates with the client to identify suitable resources and services together.	12. During initial sessions, a client shares information with a case manager and expresses that they feel judged by the case manager. The two discuss how the case manager can establish the client's trust.
Team-based: F 11	f. Case management may involve a group of professionals working together to address a client's needs. The case manager serves as a bridge to all of the integrated comprehensive services.	11. The client signs consent forms so that the case manager can receive reports from the treatment provider, mental health professional, and/or vocational-educational counselor. The case manager uses this information to coordinate services.
Meaningful: D 6	d. Services provided must be necessary to support change or recovery.	6. A case manager recommends weekly AA meetings to most of her clients, but since a new client has not been assessed as having any issues with alcohol, she does not recommend that he attend the meetings because they would not be beneficial to his progress.
Motivational: A 1	a. When working with a client, a case manager should encourage, empathize, listen, reflect, and explore any resistance a client may display.	1. A case manager asks their client open ended questions to elicit responses that empower the client to come to their own conclusions.
Change-based: H 8	h. The case manager emphasizes continual client improvement and guards against stagnation of progress.	8. A client has been in a treatment program for more than a year and after great improvements, his progress has plateaued. They decide to re-evaluate the treatment


		plan together and the case manager suggests that he focus his efforts on finding a job.
Culturally-proficient: G 3	g. Case management must account for a client's identity, culture, and ethnicity.	3. A case manager locates a non-faith-based 12-step meeting group for a client who identifies as an atheist.
Family-focused: I 2	i. When appropriate, case management should take a holistic approach by including the client's family in the recovery process.	2. A case manager suggests that a veteran bring her family to one of their meetings to discuss the treatment plan with them and make a referral for family therapy.
Accountability-based: E 4	e. Case managers should ensure that clients focus on how their behavior contributes to their success. Case managers should encourage clients to recognize behaviors that are not consistent with treatment plan goals.	4. A client loses his job because he showed up drunk. At his next session, his case manager asks him to reflect on how his behavior contributed to his termination.
Public-safety focused: B 7	b. Case managers must prioritize the need for protection and well-being of the surrounding community, while also advocating for their client.	7. A veterans treatment court case manager has a client who drove to his session after having a few drinks. The case manager holds onto his client's key, insists that he take a taxi home, and reports the behavior to the court.
Ethically sound: K 10	k. Case managers need to be aware of appropriate boundaries with clients. Also, case managers must always respect the confidentiality of their relationship with a client.	10. A case manager sees a client at a restaurant, and the client invites the case manager to dine together. The case manager politely declines, and during the next case management session reminds the client about the boundaries of their relationship.

## Case Planning

Time: 10 minutes

### Case Planning

- Goals
- Action steps
- Resources
- Time frames
- Consider risk level
- Collaboratively identify target behaviors



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#### Instructor:

We've talked a lot about the concepts and models of case management. Now let's talk about case plans. An effective, focused case plan can help reduce an individual's risk of reoffending by targeting the risk factors—or criminogenic needs—that tend to lead to recidivism. A case plan is a written document that outlines goals, action steps, resources, and time frames. Ideally, it is created collaboratively between the case manager, the client, and the treatment team during the first few sessions of case management. The case manager should consider all available resources, strengths, and needs of the client when developing the case plan. Goals and action steps should be achievable, measurable, and in an appropriate order. Interventions should be based on the individual's risk level and specifically aimed to affect target behaviors.

The case plan is a roadmap for the case manager to refer to when working with the client to gauge his or her progress toward meeting goals, and is updated periodically based on the client's evolving needs.

What are the critical factors that go into a case plan?

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	<p><b>Ask:</b></p> <p>If the goal of the case plan is to reduce risk, what information should we start with when preparing to develop the plan?</p> <p><b>Anticipated Response:</b></p> <p>The person's criminogenic needs.</p>
	<p><b>Instructor:</b></p> <p>That's right. The research is very clear that in order to reduce an individual's risk of reoffending, the focus must be on the criminogenic needs.</p>
	<p><b>Ask:</b></p> <p>What other piece of information from the risk assessment is important in creating the case plan?</p> <p><b>Anticipated Response:</b></p> <p>The individual's risk level.</p>
	<p><b>Ask:</b></p> <p>Why do we want to include that on the plan?</p> <p><b>Anticipated Response:</b></p> <p>It is important for calculating the dosage and intensity of programs and interventions.</p>
	<p><b>Instructor:</b></p> <p>Correct! By including the risk level and criminogenic needs on the case plan, we can match programs and interventions to the individual needs of the person.</p>

## SMART Case Plans

Time: 10 minutes

### SMART Case Plans

**S**pecific: the client should know what needs to be done and why

**M**easurable: action steps should be behaviorally based and described in clear and easy to understand terms.

**A**chievable: action steps should be attainable to the individual

**R**ealistic: the individual should have the skill set required to complete each action step.

**T**ime-Bound: established time frames encourage completion of action items in a timely, yet realistic manner.

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**Ask:**

How should a case manager explain the purpose of the risk assessment to a veteran?

**Anticipated Response:**

“The risk assessment is a tool to identify areas in your life that put you at a higher risk of reoffending. By understanding what your risk factors are, we can create a plan to lower your risk of returning to the justice system.”



**Ask:**

From this conversation, how would a case manager proceed to developing a case plan?

**Anticipated Response:**

Elicit feedback and suggestions from individuals about what they think might help lower these risks.



**Instructor:**

Right. At this point, case managers should work with individuals to develop goals that indicate the specific changes they need to make in order to decrease their risk. These goals should be broken down into small, incremental tasks, or action steps, that are “**SMART**”:

- **S**pecific: The individual should know exactly what needs to be done and why.
- **M**easurable: Action steps should be behaviorally based and described in clear and easy-to-understand terms. The case manager and the individual should know exactly when the steps have been achieved.
- **A**chievable: The action steps should be attainable to the individual.

- **Realistic:** The individual should have the skill set required to complete each action step.
- **Time-bound:** Established time frames encourage completion of action items in a timely, yet realistic manner.

The case manager and the individual should focus on only one or two goals at a time. Focusing on more than one or two goals at once may be ineffective. Finally, each goal should list the specific interventions and services necessary for accomplishing the desired outcomes and the time frame for achieving each task.

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## Skills Building: Case Study

Time: 30 minutes

### Skills Building: Case Study

- What goals, action steps, strengths, and resources would you consider when developing Victor's case plan? What additional information would you try to get to help you develop the case plan?

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#### Instructor Note:

Divide participants into small groups. Have each group develop a case plan to present to the group.







#### Discussion Group:

Now that we reviewed the principles of case management and case planning, you're going to talk through the creation of a sample case plan. Please turn to page 46 of your Participant Manual to find a case study about a veteran named Victor. In this scenario, you're a case manager in a court-based program and Victor is your new client.

*Victor is a 27-year-old veteran of the war in Afghanistan. Back home in Colorado, Victor was involved in an automobile collision that resulted in severe injuries to the individuals in the car he hit. He tells you that he is experiencing feelings of sadness and guilt because of the collision. He has been charged with a DUI and has lost his driver's license. He is a skilled contractor, but needs his car to get to work. He tells you he needs to get his license back to return to work. He acknowledges that since the war, he drinks more alcohol than he would like and his family has been encouraging him to seek help. During your initial meeting, Victor appears to lose focus, stating that it was because he has been having trouble sleeping.*

What goals, action steps, strengths, and resources would you consider when developing Victor's case plan? What additional information would you try to get to help you develop the case plan?

Take ten minutes with your group to discuss your answers.

	<p><b>Instructor:</b></p> <p>Okay, let's come back together to review. What goals, action steps, strengths, and resources would you consider when developing Victor's case plan? What additional information would you try to get to help develop the case plan?</p>
	<p><b>Instructor Note:</b></p> <p>Facilitate a group discussion. Use the following answer key as a reference.</p>
	<p><b>Answer Key:</b></p> <p>Goals:</p> <ul style="list-style-type: none"> <li>• Get license</li> <li>• Cut back on drinking (additional information needed)</li> <li>• Maintain employment</li> <li>• Reduce feelings of sadness and guilt</li> <li>• Improve concentration and sleeping</li> </ul> <p>Action Steps:</p> <ul style="list-style-type: none"> <li>• Take steps to regain license (additional information needed)</li> <li>• Be assessed for mental health issues (substance use disorder, depression, anxiety, PTSD)</li> </ul> <p>Strengths:</p> <ul style="list-style-type: none"> <li>• Skilled contractor</li> <li>• Family support</li> <li>• Acknowledges drinking problem</li> </ul> <p>Resources:</p> <ul style="list-style-type: none"> <li>• Family</li> <li>• Need additional information</li> </ul>
	<p><b>Instructor:</b></p> <p>Excellent work! You all are ready to be case managers! Before we end this lesson and take a break, are there any questions?</p>

## Break for Day

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# **VICTOR DAY 4**

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## Lesson 2: Responsivity in the Justice System

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### Lesson Overview:

The collateral consequences for someone involved in the justice system can be difficult to overcome. Negative consequences can include having a harder time finding a job, difficulty finding safe and sustainable housing, and interruptions in family dynamics and relationships. For a veteran, this can also include an interruption of VA benefits if they are incarcerated.

For these reasons, the justice system must aim to be responsive to the needs of veterans and practitioners should assist veterans by utilizing appropriate court- and corrections-based programming. Veterans treatment courts are perhaps the most well-known example of court-based veterans justice programs, but there are many ways that courthouses can and should be responsive to the needs of veterans in the criminal justice system, even outside the VTC setting. This section will introduce several aspects of responsivity in the criminal justice system: veterans treatment courts, procedural justice, diversion programs, domestic violence issues, and programming in prisons and jails. The section will begin with an introduction to the sequential intercept model for justice-involved veterans.

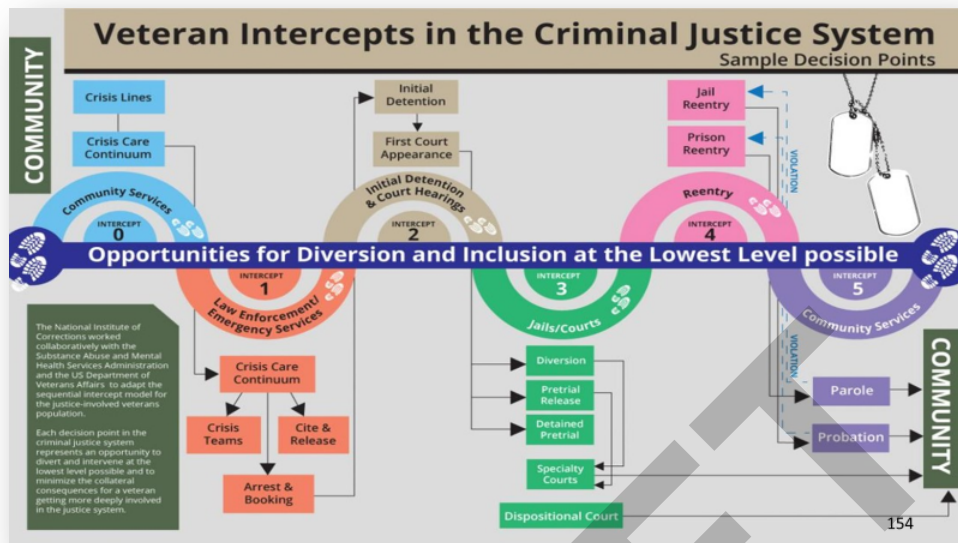
### Topics:

- Sequential Intercept Model for Justice-Involved Veterans (15 minutes)
- Introduction to Veterans Treatment Courts (20 minutes)
- Key Components of Veterans Treatment Courts (25 minutes)
- Veterans Treatment Court Team Members (15 minutes)
- Veteran Peer Mentors (5 minutes)
- Accountability (5 minutes)
- Procedural Justice (25 minutes)
- Domestic Violence (35 minutes)
- Jail-Based Programming (10 minutes)
- Using Screening to Streamline Sentencing and Disposition for Veterans (10 minutes)
- Conclusion (5 minutes)

**Total Instruction Time:** 2 hours, 50 minutes

# Sequential Intercept Model for Justice-Involved Veterans

Time: 15 minutes



## Instructor:

The National Institute of Corrections worked collaboratively with the Substance Abuse and Mental Health Services Administration and the VA to create a sequential intercept model for the justice-involved veterans population. Each decision point in the criminal justice system represents an opportunity to divert a veteran from jail and to minimize the collateral consequences for a veteran getting more deeply involved in the justice system.

The sequential intercept model for veterans outlines six key decision points that are opportunities for justice-system diversion and connection to VHA services. We will look more closely at these intercept points now, which can be found on page 49 of your Participant Manual.

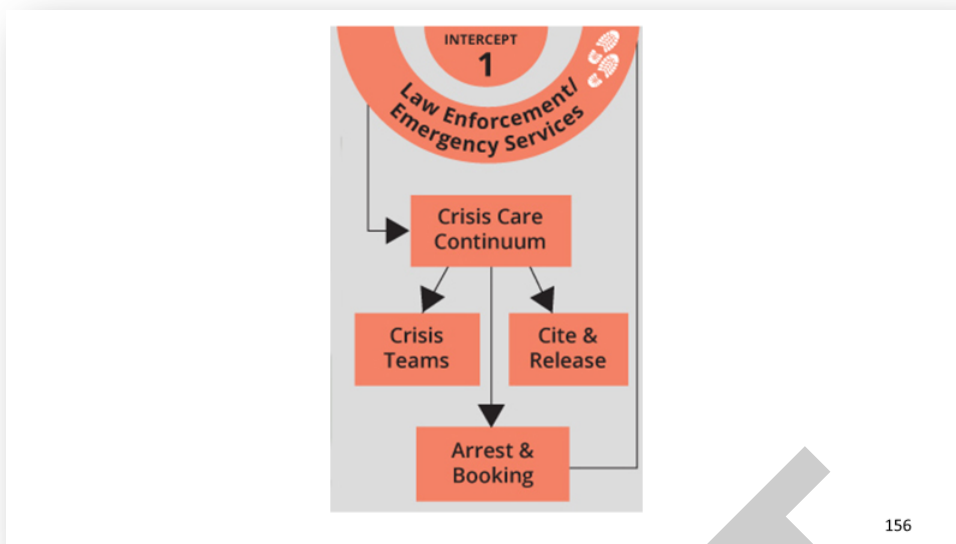


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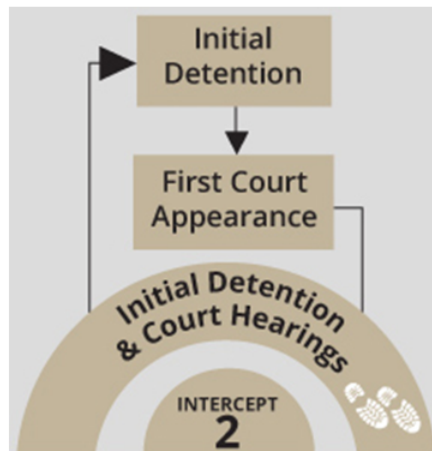
**Instructor:**

The first potential decision point—Intercept 0—occurs in the community. When veterans call crisis lines, phone line operator, crisis teams, or hospital staff have the opportunity to enroll or refer for enrollment in community mental health services or VA healthcare. Veterans should also be assisted at this point with securing transitional housing, and residential or outpatient treatment in order to deter them from criminal justice involvement.



**Instructor:**

Intercept 1 is an opportunity for law enforcement or emergency services to determine eligibility and enrollment for veterans' services. Local bookings teams can determine veteran status, and bail entities can refer for healthcare enrollment.

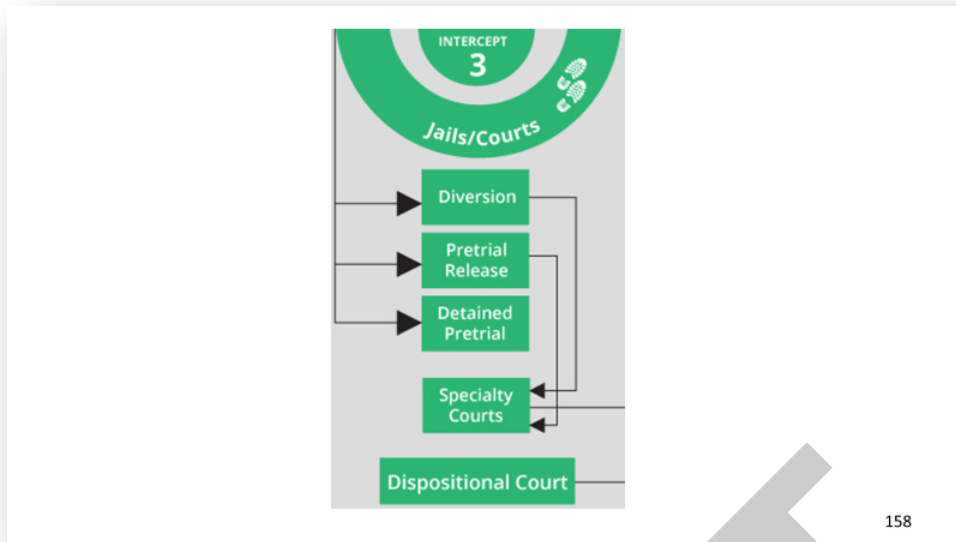


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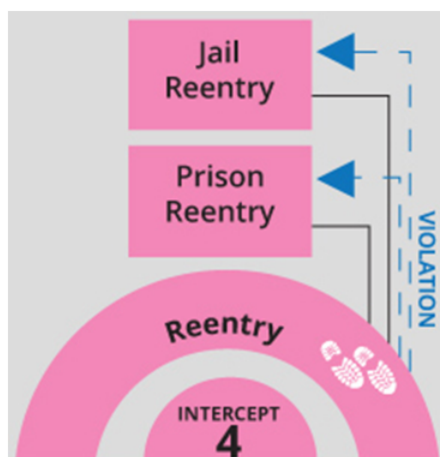
**Instructor:**

Intercept 2 occurs at the initial detention and court hearings. At the first court appearance, the public defender or prosecutor can refer veterans for assessment and eligibility to veterans treatment court, which we will discuss in more detail soon. The prosecutor can also recommend a deferred prosecution agreement or explore other diversion options depending on what is available in the jurisdiction. Corrections officers can also determine veteran status, and can make a referral to mission-specific housing if appropriate, or to a VJO or the VA directly for a benefits appointment upon release. At this point, the VJO and the HCRV also conduct outreach to identify veterans.



**Instructor:**

Intercept 3 occurs in the jails and courts, and includes many of the diversion options we just learned about at the first court appearance. During this time, the VJO and HCRV conduct outreach to identify veterans, and the public defender or prosecutor may refer the veteran for veterans treatment court evaluation. Additionally, the veterans treatment court clinician or probation officer may assess the client and enrolls them in the VTC or refer them to a VA VJO specialist. Jail intake also determines eligibility for veteran/mission specific housing while awaiting release or referral to VTC program.

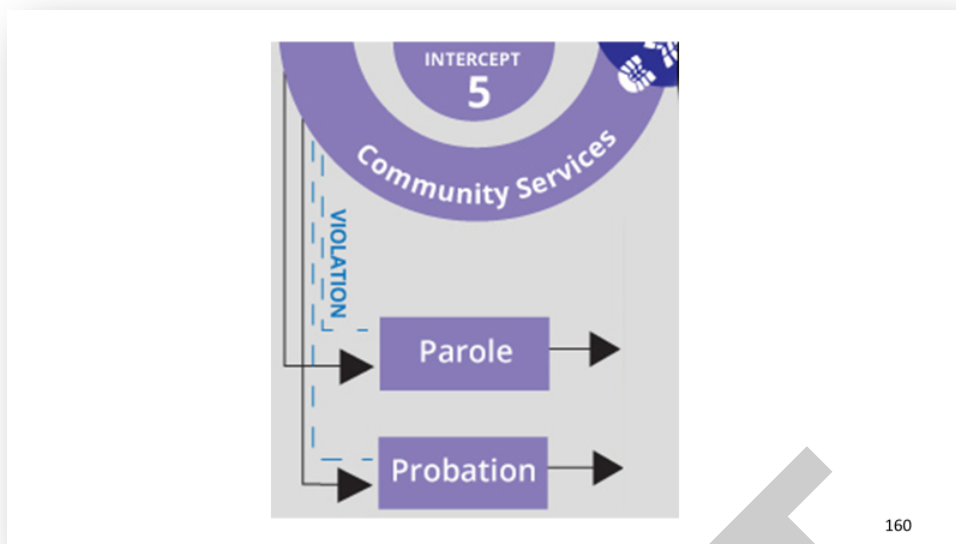


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**Instructor:**

Intercept 4 occurs during reentry into the community. At this point, the department of corrections, probation, or jail discharge planners determine eligibility for and assist enrollment in VA health services prior to discharge. Veterans also should be enrolled in transitional community services.



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**Instructor:**

Intercept 5 represents the parole and probation period when veterans are back living in their communities. If veterans are living at transitional or halfway houses, staff there can enroll them in VA healthcare if parole/probation didn't enroll them prior to discharge. Additionally, the VA HCRV/VJO specialist also enrolls veterans on probation/parole in VA healthcare benefits/community treatment.

We'll now spend some time learning more about one specific intervention that we've mentioned several times throughout this course—veterans treatment courts.

# Introduction to Veterans Treatment Courts

Time: 20 minutes

Introduction to Veterans Treatment Courts

Why a veterans treatment court?

Targeted services for a unique population	Collaborative partnerships	Shared experiences and traditions	Staff empathetic to military culture
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## Instructor Note:

In this section, you will need to ensure the audio-visual equipment is working. You will show the participants a video of Judge Robert Russell discussing the first veterans treatment court.



## Instructor:

The VA is the federal government's response to providing veterans with specialized services. The criminal justice system itself has its own responses; these include veterans treatment courts, diversion programs, and jail-based programming. There are over 350 VTCs in the country and we will start by talking about them.



## Ask:

Some have wondered, why create a treatment court specific to veterans? Why not work with these individuals within established drug and mental health treatment courts? Why do you think?

## Anticipated Responses:

Veterans have special needs; Service members and their families experience unique stressors as part of the military experience.



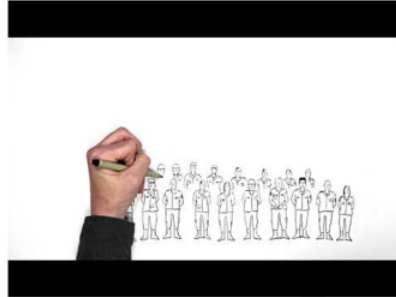
## Instructor:

There are many answers to this question; perhaps the most significant is that veterans are a niche population with unique needs. Service members have many shared experiences, which set them apart from their non-military peers. Traditional community services may not

	adequately suit their needs.
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## Introduction to Veterans Treatment Courts



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### Instructor:

In January 2008, the first veterans treatment court opened in Buffalo, NY under the tutelage of Judge Robert Russell. Judge Russell and his staff recognized that a veteran could have a better outcome when working with other veterans. The judge enlisted two veterans on his team to speak with a veteran who was non-compliant in court. That veteran-to-veteran conversation was the seed that blossomed into the veterans treatment court movement across the country. Today, there are more than 350 VTCs in jurisdictions across the USA. Let's hear from Judge Russell directly.



### Multimedia:

Play video of Judge Robert Russell discussing the reason for starting veterans treatment court. <https://www.youtube.com/watch?v=psmZ3gnl5Ek>



### Instructor:

Now that you know where it started, here's a video about how it works.



### Multimedia:

Play the video from Justice for Vets website: What is a veterans treatment court?  
<https://www.youtube.com/watch?v=sxeAMKCav5I>



### References:

Link to Buffalo Veterans Treatment Court:

<http://www.buffaloveteranscourt.org>  
<https://www.youtube.com/watch?v=psmZ3gnl5Ek>

Link to the Justice for Vets video:

<https://www.youtube.com/watch?v=sxeAMKCav5I>

## Overview of Veterans Treatment Courts

- Court and healthcare integration
- Military culture integration
- VJOs and peer mentors
- Proliferation of new VTCs across the country

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### **Instructor:**

The veterans treatment court model is designed to rehabilitate veterans by integrating court and mental healthcare services to meet the needs of justice-involved veterans. As with a traditional treatment court model, a veterans treatment court team is comprised of a multidisciplinary panel of criminal justice professionals. Some unique aspects of a VTC are the integration of military culture into court proceedings and the addition of a VJO and peer mentors to the court team, although peer mentors occupy a unique “quasi-team member” role.

A typical veterans treatment court involves screening criminal defendants for their veteran status and then identifying veterans with eligible charges and clinical needs for admission to a VTC. Like regular drug courts, some VTCs will require the veteran to plead guilty to their charge, while other will operate on a “pre-plea” basis. Either way, if a veteran completes the requirements of the program, which usually include sobriety, stable housing, and employment where possible, no jail time will be imposed, and the charges might be erased from the veteran’s record. While in the program, the veteran is required to attend regular court hearings, treatment sessions, and case management sessions. He or she may also be subject to conditions while in the community, such as a curfew, no contact order, or an alcohol monitoring device. Participants also must submit for regular drug screenings. If a veteran is compliant with the program, the requirements will be reduced. Often, this is accomplished through “phases.” For example, if a veteran is compliant and progresses to the next phase of the program, the frequency of their court appearances and supervision appointments may be reduced. Incentives and sanctions are imposed by the VTC team to encourage or modify behavior.

Eligibility for a VTC varies from jurisdiction to jurisdiction. Usually a court accepts veterans who have a mental health and/or a substance use disorder that is related to their criminal

behavior. Different courts accept different types of charges. For example, some don't accept violent offenses or DUIs, while others accept any type of charge on a case-by-case basis. Participation in VTC is always voluntary.

VTCs have spread across the country over the past ten years. By December 31, 2017, there were more than 360 VTCs in the U.S. with hundreds more in various stages of planning and implementation. Modeled after the 10 Key Components for Adult Drug Court, VTCs have their own ten key components, which we will review now. After that, we will look a little closer at some of the other defining concepts of the VTC model.

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## Key Components of Veterans Treatment Courts

Time: 25 minutes

Key Components of veterans treatment court	
The <b>10 Key Components</b> of veterans treatment court can be found in your Participant Manual	With your group members, come up with a practical application or example of your assigned component(s).



### Instructor Note:

Divide the participants into small groups. Assign each group 1-3 components depending on the number of groups (assign all 10 components). The groups will take 5-7 minutes to come up with an example of how each component can be practically applied. The components are listed in the Participant Manual. You will write down each suggestion on the flipchart afterwards.



### Discussion Group:

Now, we're going to get into small groups to identify a practical example of the 10 Key Components of veterans treatment courts, which are outlined in your Participant Manual on page 50. Use the manual to list your responses. [Assign each group several components]. Let's take five to seven minutes to discuss and write down our responses and then we'll share aloud. You will only have three components assigned to your group, and can use the remaining space to fill in the blanks from the other groups' responses.

#### Key Component #1

Veterans treatment court integrates alcohol, drug treatment, and mental health services with justice system case processing.

#### Key Component #2

Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.

#### Key Component #3

Eligible participants are identified early and promptly placed in the veterans treatment court program.

#### Key Component #4

Veterans treatment court provides access to a continuum of alcohol, drug, mental health and other related treatment and rehabilitation services.

#### Key Component #5

Abstinence is monitored by frequent alcohol and other drug testing.

#### Key Component #5

A coordinated strategy governs Veterans Treatment Court responses to participants' compliance.

#### Key Component #7

Ongoing judicial interaction with each veteran is essential.

#### Key Component #8

Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.

Key Component #9

Continuing interdisciplinary education promotes effective veterans treatment court planning, implementation, and operations.

Key Component #10

Forging partnerships among veterans treatment court, Veterans Administration, public agencies, and community-based organizations generates local support and enhances veteran treatment court effectiveness.



**Flipchart:**

After participants are done discussing in small groups, ask each group to share their responses. Facilitate discussion of examples and record on flipchart.



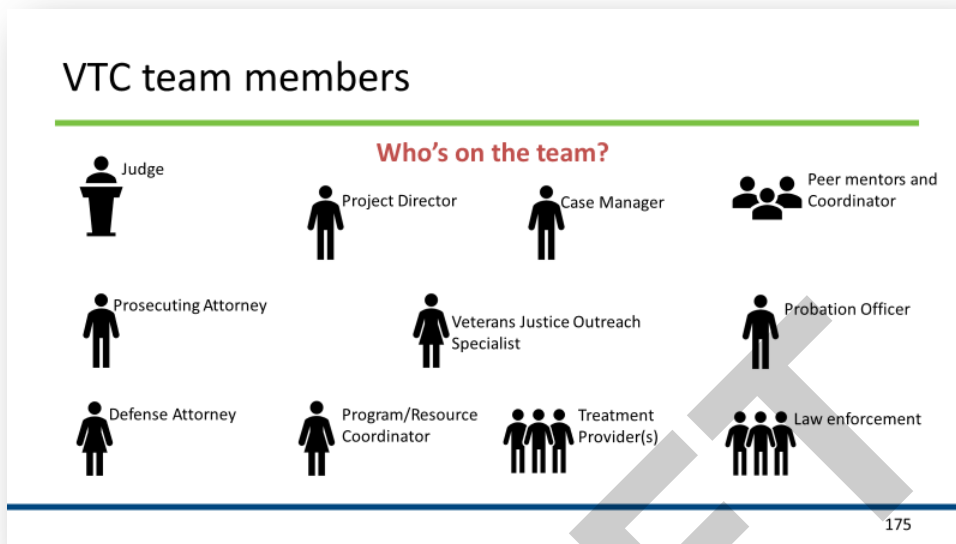
**Instructor:**

Now that we've reviewed the key components, let's get into more specifics about how VTCs operate.

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# Veterans Treatment Court Team Members

Time: 15 minutes



## Instructor:

So, who's on the VTC team?

The VTC team is a collaboration of various criminal justice professionals. Depending on the jurisdiction, some team members may have multiple roles. This list on the slide represents some of the people you may find on the team.

The team's major responsibilities include holding pre-court staffing meetings and attending court hearings. During these meetings, the team discusses each veteran's program compliance, including drug use, treatment engagement, and other information. The team will discuss potential incentives and sanctions, and treatment plan modifications that include a reduction or increase in services. In the court hearings, team members will have a chance to hear from the participant before the judge makes any decisions about a person's progress.

We will now brainstorm together about the role of each VTC team member.



## Instructor Note:

In the following section, if participants do not contribute the provided anticipated responses, elaborate/provide them with the correct response.









## Ask:

What is the role of the **judge** on the VTC team?

## Anticipated Responses:

The judge is the final decision-maker on what will occur in the courtroom; administers

	incentives and sanctions; speaks to each veteran from the bench to build a relationship
	<p><b>Ask:</b> What is the role of the <b>prosecutor</b> on the team?</p> <p><b>Anticipated Responses:</b> The prosecutor makes decisions about eligibility; requests sanctions where appropriate; makes submissions to the judge about compliance and supervision; ensures public safety; acts in a non-adversarial manner when dealing with defense</p>
	<p><b>Ask:</b> What is the role of the <b>defense attorney</b>?</p> <p><b>Anticipated Responses:</b> Represents the veteran in pre-court and court; ensures that his client's legal rights are protected; works collaboratively with the prosecutor and the rest of the team to ensure the best outcome for each participant</p>
	<p><b>Ask:</b> What is the role of the <b>coordinator/director/resource coordinator</b>?</p> <p><b>Anticipated Responses:</b> Performs administrative functions; case management; provides progress updates to the team; liaises with community providers</p>
	<p><b>Ask:</b> What is the role of the <b>case manager</b>?</p> <p><b>Anticipated Responses:</b> Prepares progress reports; engages with treatment providers; provides case management to veterans; meets with veterans to make sure their needs are being met; collects toxicology screens.</p>
	<p><b>Instructor:</b> Note that we discussed the role of the VJO in the VA section so you should have a handle on that.</p>
	<p><b>Ask:</b> What is the role of the <b>probation officer</b> on the team?</p> <p><b>Anticipated Responses:</b> Supervises participants; makes sure participants are obeying the rules of the court; conducts home visits to ensure that the veteran is residing in a safe environment; does toxicology screens; reports to the court in compliance and drug use; performs case management functions in some jurisdictions</p>



**Ask:**

What is the role of **law enforcement** on the VTC team?

***Anticipated Responses:***

Provides the team with information from the community; executes warrants for missing participants, improves relationships between the clients and law enforcement

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## Veteran Peer Mentors

Time: 5 minutes

## Veteran Peer Mentors



- **Veteran peer mentors** offer support to veterans in the justice system by spending one-on-one time with the veteran before and after proceedings of the VTC.
- Peer mentors' support throughout the treatment process increases the likelihood that a veteran will remain in treatment and improves his or her chances for law-abiding behavior and sobriety

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### Instructor:

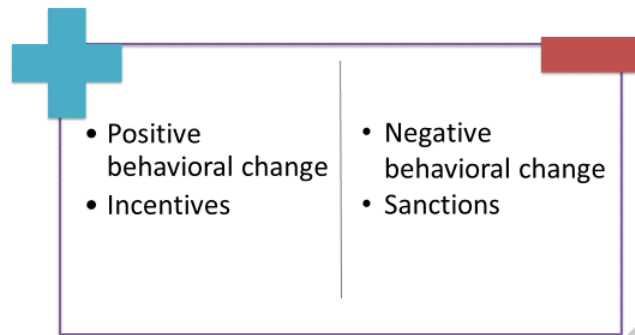
Great! Now we'll discuss the role of the veteran peer mentor, which is a unique component of many veterans treatment courts. Many VTC teams include volunteer veteran mentors, who support the participants throughout the recovery process. Thinking back to the Military and Veterans Culture Module, we know that military culture creates strong bonds between veterans, which facilitates relationships between veteran peer mentors and veteran participants. Some veterans might find it challenging to open up to a non-veteran about their experiences, and speaking with a peer mentor is an opportunity to feel connected to someone who understands his or her experiences. Peer mentors are often described as being *of* but not *in* the VTC system. Mentors function as "battle buddies" to their charges and do not report specific information to the court about their mentee unless their mentee is threatening themselves or others.

In courts with a large roster of veterans, the peer mentor coordinator may try to match participants with mentors from the same branch of service or era of combat to help strengthen the bond. Mentors may attend pre-court staffing and status hearings; however, mentors are not treatment providers or social workers, and they do not testify in court. Their responsibility is to support the veterans. Justice for Vets, a branch of the National Association of Drug Court Professionals, runs a two-day "Mentor Corps Boot Camp" for anyone who wants to become a VTC mentor. The boot camp is designed to provide mentors with the knowledge and skills to support veterans throughout the program.

## Accountability

Time: 5 minutes

## Veteran Accountability in Court



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### Instructor:

Now let's take a deeper look at how the notion of accountability plays out in the VTC setting. One element that resonates throughout all treatment courts, including VTCs, is the emphasis on personal accountability and the utilization of skills learned while in the program. While in a VTC program, a veteran remains in the community, and the court provides a therapeutic environment coupled with a high level of accountability. Veterans are expected to attend regular court hearings, participate in the development of their treatment plans, submit toxicology screens, and engage in community groups and pro-social activities. Moreover, veterans are always required to be honest with the court, even if that means admitting to sanctionable behavior. Veterans are held accountable for their actions through the imposition of incentives and sanctions.

Examples of incentives are verbal praise from the judge, applause, phase advancement, gift cards, and other positive tangible and intangible offerings. Sanctions may be imposed for negative behavior such as drug use or missing a treatment session, and may include writing essays about behavior, sitting in the jury box for the day, being called later or last, community service hours, incarceration for brief periods, and potentially expulsion from the VTC.

VTCs should not sanction veterans who are struggling in treatment, as long as they are complying with the rules of the program. In such cases, the appropriate response is for the treatment provider and the court team to review the veteran's treatment plan and make therapeutic adjustments as necessary.

## Break



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## Procedural Justice

Time: 25 minutes

### Procedural Justice

#### Consider a time when...

- You had to wait in a long line
- You were treated disrespectfully
- You were the lay person and someone in a position of authority failed to explain something important to you
- Your concerns weren't taken seriously

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**Ask:**

We're going to move on from talking specifically about veterans treatment courts to a discussion of the general principles of procedural justice. Who is familiar with the term "procedural justice"?

**Anticipated Responses:**

Responses will vary.



**Instructor:**

We've all experienced a lack of procedural justice in our lives – when we were the lay person and were not treated well by a person of authority. Think of a time in your life when you were a customer or consumer and were not treated properly.



**Ask:**

How do you wish you had been treated?

**Anticipated Responses:**

Respectfully; with eye contact; addressed by name; given an explanation; invited to ask questions and be heard



**Ask:**

Now, let's think about our jobs as court professionals. What does the public want when they come through a courthouse?

**Anticipated Responses:**

Efficiency; fairness; justice; to avoid jail or bad outcomes



**Instructor:**

Although common knowledge would presume that the average court user has an expectation of avoiding bad outcomes, research has shown us that they place a higher value on how they were treated regardless of their case outcome. We want to explore how criminal justice professionals can help court users reach these expectations.

DRAFT

## What is procedural justice?

**Procedural** justice is the perception that the process is fair, as opposed to **distributive** justice, or whether or not the outcome is fair.

When participants feel that...

Voice	• Their side of the story is heard.
Respect	• They are treated with dignity and respect.
Neutrality	• The decision-making process is biased and consistently applied across all demographics (e.g. race, age, gender).
Understanding	• They understand their rights and the process.

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### Instructor:

The concept of procedural justice explains that justice-involved individuals are more likely to obey court orders based on the level of perceived fairness of court procedures and quality of interactions with court staff during an their court experience. Research has determined that there are four key elements of procedural justice. When court users feel that they were treated with dignity and respect, understood the process, had a chance to be heard, and believe the decision-making process was neutral and unbiased, they were more likely to accept decisions and obey court orders. The research summarizes the four key elements as: respect, understanding, voice, and neutrality.

As court system professionals, we should all work to embody the principles of procedural justice into every aspect of our work, especially interaction with the public. Let's review some examples of each. I'm going to give you verbal and non-verbal examples of each. These examples will apply to all of us, whether we're judges or court officers or jail staff. You can follow along in your Participant Manual on page 53.

### Voice—verbal strategies:

- Provide individuals with an opportunity to tell their side of the story
- Tell individuals when there will be an opportunity to speak/ask questions
- Paraphrase what you hear to demonstrate active listening
- Consider other opportunities to solicit feedback about the experience (e.g., surveys, comment cards)

### Voice—non-verbal strategies:

- Sincere tone of voice
- Open-handed gestures
- Lengthy pause

- Have eye contact when listening, or explain why not
- Orient your body toward the speaker

**Neutrality—verbal strategies:**

- State fairness as a goal
- Explain the decision-making process and possible constraints
- Avoid perceptions of preference for certain court players, e.g., prosecutors over public defenders

**Neutrality—non-verbal strategies:**

- Use consistent behaviors with each person
- Use a neutral but open face: relax mouth, lift eyebrows slightly

**Respect—verbal strategies:**

- Introduce yourself and the format of the session
- Greet each individual by name
- Thank individuals for their on-time appearance and cooperation
- Inform participants that you might have to interrupt to keep them on track; respectfully redirect if necessary

**Respect—non-verbal strategies:**

- Monitor your vocal tone and inflections
- Turn toward and have eye contact with person with whom you're interacting
- Avoid confrontational gestures
- Work to maintain a respectful frame of mind – your attitude will be reflected in your non-verbal communication

**Understanding—verbal strategies:**

- Use initial dialogue to assess English language abilities
- Use simple, non-jargon words
- Ask individuals to repeat back their understanding
- Tell individuals they can have a short break to ask their lawyer questions
- Check clarity, placement, and amount of signage
- Check reading level of forms and written materials
- Ensure that rules and procedures are written down and explained orally

**Understanding—non-verbal strategies:**

- Use natural pace and inflections, especially when delivering routine statements
- Pause, make eye contact, and check reactions
- Slow down if person seems confused or overwhelmed

One benefit of this approach is that many procedural justice improvements require little

money or training, and many of its promising practices are already likely being used by all of you. The trick is to deliver them consistently and as widely as possible across your agency and courthouse.

Let's think about some specific examples that relate to working with veterans. One example is that many VTCs fly American and military service flags to make the participants feel welcome and at ease. Another example is training court officers to allow veterans to stand in court or sit in a particular seat which may be influenced by his or her need to be vigilant and aware of their surroundings. Basically, the concepts of procedural justice can be applied to what we learned in the Military and Veterans Culture module – for court users to feel like they're being treated fairly, they must feel like someone respects them as individuals and is respectful of their individual experience and needs.



### References:

Perceived procedural justice can increase acceptance of court decisions and reduce illegal behavior (e.g., Lind et al. 1993; Paternoster et al. 1997; Tyler and Huo 2002)

Perceived procedural justice is more influential than perceptions of the outcome (win or lose) (see Tyler 1990; Tyler and Huo 2002)

**Time: 35 minutes**

## What is domestic violence?

**Domestic violence** is a pattern of abusive behavior—emotional, physical, financial and/or sexual—that one person in a relationship uses to control the other.

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### **Instructor:**

We're going to shift gears again to spend a bit of time talking about domestic violence. Many veterans come into contact with the criminal justice system because of domestic violence. In fact, many veterans in treatment court are charged with domestic violence offenses. Domestic violence is defined as a pattern of abusive behavior—emotional, physical, financial, and/or sexual—that one person in an intimate relationship or formerly in an intimate relationship uses to control the other.



### **Instructor Note:**

Ask participants to open page 55 in their Participant Manual to the Power & Control Wheel and Assessing Risk Factors for Intimate Partner Homicide to participants and give them a few minutes to look over the sheets.



### **Resources:**

[Power and Control Wheel \(NCDSV\)](#)

[Assessing Risk Factors for Intimate Partner Homicide](#) - Dr. Jacquelyn Campbell et al.



### **Instructor:**

There are many forms of violence, intimidation, and coercion that domestic violence offenders use to control the target of their violence. Many of these overlap between emotional, physical, financial, and/or sexual. You can refer to the Power & Control Wheel handout for examples of the various forms of violence used by these offenders. Additionally, you can refer to the Risk Factor chart for a list of risk and lethality factors. When present, these factors may indicate a higher risk of increased violence, including lethality. Does anyone have any questions about material on this sheet?



**Instructor note:**

Pause for any clarification questions. Ask participants to turn to the NCADV Fact Sheet on page 58 in their Participant Manual.



**Resource:**

[National Coalition Against Domestic Violence Fact Sheet](#)



**Instructor:**

This fact sheet is a compilation of statistics related to domestic violence. The prevailing statistic is that 1 in 3 women and 1 in 4 men have been victims of domestic violence during their lifetime. In 2010, the National Intimate Partner and Sexual Violence Survey found that occurrence of intimate partner violence, sexual violence, and stalking is virtually the same among civilian and veteran populations (i.e., no statistically significant difference).

DRAFT

## **NPR audio clip: *After combat stress, violence can show up at home***



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### **Instructor:**

We know that there is a high prevalence of PTSD in the military, especially among returning combat veterans. According to the National Center for PTSD, run by the VA, there is a link between PTSD and violence. In fact, veterans with PTSD are three times more likely to be violent than veterans who don't have PTSD. When PTSD manifests as aggression, intimate partners become common targets.

We will now listen to a clip from a National Public Radio piece about combat stress and violence in the home environment. Keep in mind what we've learned about PTSD in previous modules, and how we've just defined intimate partner violence.



### **Multimedia:**

Over the speakers, play this eight-minute NPR clip.

<https://www.npr.org/sections/health-shots/2016/04/27/475908537/after-combat-stress-violence-can-show-up-at-home>



### **Ask:**

What are your reactions to the clip?

### ***Anticipated Responses:***

This is real life; it's messy and complicated; possibly dangerous or deadly; there's not enough context for some of these examples



### **Instructor:**

This may have been difficult to listen to, but it's a good example of how complicated real-life circumstances can be. In some situations, the symptoms of PTSD may manifest as violence in the home, which may result in criminal charges. Although there is no sure method for determining with certainty whether a veteran's violent actions are a result solely of PTSD or

if they're an example of coercive, controlling actions, there are factors to take into consideration. The following factors are more suggestive of non-PTSD related behavior: a recurring pattern of intent to coerce and control, a history of violence against partner(s), patterns of violent behavior, and/or prior orders of protection and court cases.

DRAFT



**Instructor:**

Many VTCs accept veterans with domestic violence charges. In some VTCs, domestic violence is one of the most common charges. Even outside of the VTC system, you may end up working with a veteran who has a domestic violence charge or a history of domestic violence.

Veterans treatment courts and justice-system professionals can use strategies to be responsive to the needs of veterans who commit intimate partner violence:

- Be aware of defendants with a history of domestic violence
  - Review current and past charges, where that information is available.
- Enhance victim safety
  - Identify local domestic violence advocates and develop a relationship with them to understand their scope of services, as well as how to best collaborate.
  - Provide linkages to victim advocates who can make outreach calls.
- Seek training opportunities
  - Seek training from local and national domestic violence experts to ensure awareness of the dynamics of domestic violence, particularly in the military context.



**Reference:**

[Breaking Barriers: Enhancing Responses in Veterans Treatment Courts and Domestic Violence Courts](#)

## Jail-Based Programming

Time: 10 minutes

### Video: Jails Increasingly Set Aside Cells for Veterans (AP)



National Institute of Corrections Barracks Behind Bars: <https://info.nicic.gov/jiv/sites/info.nicic.gov/jiv/files/Barracks-Behind-Bars-508.pdf>

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#### Instructor:

We're going to move on to talking about another aspect of the criminal justice system that is designed to be responsive to the needs of veterans. Nationwide, there are some one hundred prisons and jails with designated veterans' housing, sometimes called "veterans' pods." Many of these programs were started only in the last five years.

Some of these pods feature activities like daily flag raising, and weekly or monthly formations. Most offer individual and group counselling, often with the support of local veterans groups. The common aim of these programs is to create an esprit de corps and a "safe space" to help veterans deal with their issues and reintegrate into society. Another goal of these pods is to reduce recidivism through an emphasis on reintegration, and local results have been promising, as we'll see in this video.



#### Multimedia:

Play the video linked on the slide. Ask if anyone has any reflections or experiences to share.



#### Reference:

[https://www.washingtonpost.com/national/health-science/us-jails-increasingly-setting-aside-cellblocks-for-veterans/2018/01/10/22742192-f5c7-11e7-9af7-a50bc3300042\\_story.html?utm\\_term=.973874002fd6](https://www.washingtonpost.com/national/health-science/us-jails-increasingly-setting-aside-cellblocks-for-veterans/2018/01/10/22742192-f5c7-11e7-9af7-a50bc3300042_story.html?utm_term=.973874002fd6)

<https://www.nbcnews.com/news/us-news/prisons-experiment-cell-blocks->

[military-veterans-n721306](#)

NIC Barracks Behind Bars:

<https://info.nicic.gov/jiv/sites/info.nicic.gov/files/Barracks-Behind-Bars-508.pdf>

DRAFT

# Using Screening to Streamline Sentencing and Disposition for Veterans

**Time: 10 minutes**

Practice Recommendations for Justice-Involved Veterans based on Risk and Need		
NEED (Diagnosis)	RISK (Prognosis)	
	High	Low
	Referral to VTC or other treatment court: <ul style="list-style-type: none"> <li>• Case supervised by multidisciplinary team</li> <li>• Intensive treatment and habilitation</li> <li>• Frequent drug testing, court hearings, incentives &amp; sanctions</li> <li>• Charges dropped or reduced upon completion of treatment</li> </ul>	Referral to VA: <ul style="list-style-type: none"> <li>• Case supervised by VJO or VSR case manager</li> <li>• Intensive treatment and habilitation</li> <li>• VJO or VSR monitors compliance in treatment and reports progress to probation, court and prosecutor</li> <li>• Charges dropped or reduced upon completion of treatment</li> </ul>
	Referral to intensive probation: <ul style="list-style-type: none"> <li>• Case supervised by probation officer</li> <li>• Frequent drug testing, probation sessions, home or employment visits, incentives &amp; sanctions</li> <li>• Intensive habilitation (e.g., job training, housing)</li> <li>• Probation term reduced contingent on satisfaction of conditions, engagement in prosocial activities</li> </ul>	Referral to pre-trial diversion: <ul style="list-style-type: none"> <li>• Case supervised by pretrial officer</li> <li>• Brief psycho-educational groups (e.g., alcohol education)</li> <li>• Charges dropped or reduced upon completion of brief curriculum</li> </ul>

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## Instructor:

Particularly if an individual has been found guilty of a serious felony such as assault or robbery, or a serious misdemeanor such as driving while intoxicated (DWI) or domestic violence, the probation department may perform a pre-sentence investigation, or pre-sentence report, to assist the court in determining a suitable disposition or sentence.

Based on the results of the pre-sentence report or investigation, the defendant may be found suitable for a community-based alternative, such as probation or veterans treatment court, in lieu of jail or prison. He or she may also be eligible for a diversionary disposition, in which the guilty plea or verdict is held in abeyance pending completion of treatment. Successful graduates may have the conviction vacated or withdrawn, and the arrest or conviction may be expunged from their legal record. Some states, such as New Jersey, now have law that mandate a veterans diversion program in every jurisdiction.

The decision about what to offer a veteran often lies with prosecutors, but law enforcement or judges may also be able to recommend or order certain types of diversion or alternative sentence. Selecting a suitable disposition requires careful attention to the principles of risk, need, and responsivity discussed in previous modules. Recall that delivering too much, too little, or the wrong kind of services wastes resources and can worsen outcomes. Although no scientific studies have confirmed the best way to match veterans to treatment and supervision services, evidence from other justice-involved populations suggests dispositions should vary based on participants' risk and need

profiles.

We originally talked about the Quadrant Model in the risk need responsivity section. A version of the Quadrant Model for justice-involved veterans is depicted in the slide. The service recommendations for the four quadrants are derived from findings in other criminal justice populations. The effectiveness of these case plans and matching procedures need to be researched and validated for veterans in future research studies, but until then, they serve as a useful, evidence-informed practice for matching veterans to services and criminal justice interventions.

Veterans in the upper left quadrant are high risk and high need. These individuals typically require a combination of intensive supervision, treatment, and habilitation services. Veterans treatment court is an example of a program that was developed to deliver a full menu of these services. VTCs provide intensive supervision by the court and a multidisciplinary treatment team, frequent drug and alcohol testing, and incentives and sanctions. In addition, participants receive intensive treatment and habilitation services, including being paired with a veteran peer mentor. Ideally, successful graduates should have their charges dropped or reduced to avoid negative collateral consequences resulting from having a criminal record, such as a loss of voting rights or access to public housing.

Veterans in the upper right quadrant who are low risk and high need typically require an emphasis on treatment and habilitation, but usually do not require intensive monitoring by the criminal justice system. In fact, they may get worse if they are required to interact with high-risk peers in court or probation sessions. VJOs, VSRs, or case managers are usually trained to refer such individuals to the VA or other health services, monitor their compliance in treatment, and report progress information to the court. Again, those who successfully complete treatment should ideally have their criminal charges dropped or reduced.

Veterans in the lower left quadrant who are high risk and low need typically require an emphasis on supervision and habilitation, but usually do not require substance use or mental health treatment. These cases may be supervised by probation and should receive frequent drug and alcohol testing where indicated, as well as incentives for achievements and sanctions for infractions. They should also receive habilitation services focusing on teaching them pro-social ways to solve problems and deal with interpersonal conflicts without resorting to crime or substance use.

Finally, low risk and low need veterans in the lower right quadrant are often suited for brief psycho-educational counseling and diversion out of the criminal justice system. These cases may be managed by pretrial services and should not receive a criminal record if they are compliant with a brief course of counseling.

## Conclusion

Time: 5 minutes

**Conclusion**

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- Case management**
  - Need assessment
  - Case management roles, principles, functions, and tasks
  - Case planning
- Responsivity in the criminal justice system**
  - Veterans treatment courts
  - Veteran peer mentors
  - Accountability
  - Procedural justice
  - Domestic violence
  - Court and jail-based programming
  - Sentencing and disposition for veterans

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**Instructor:**

Today we looked at many aspects of how criminal justice professionals can be responsive to the needs of justice-involved veterans. We discussed case management, the VA, and different types of court- and jail-based programming for veterans. Now, you'll take your end-of-module quiz before we take a short break.

## Module 5 Quiz

**Time: 15 minutes**

**Instructions:** Based on your knowledge of the quadrant model discussion in Lesson 2, fill in the blanks below with the level of risk and need (high/low) to complete each service recommendation.

1. Veterans identified as **high** risk / **high** need typically require a combination of intensive supervision, treatment, and habilitation services.
2. Veterans identified as **low** risk / **low** need often benefit from brief psycho-educational counseling and diversion out of the criminal justice system.
3. Veterans identified as **low** risk / **high** need typically require treatment and habilitation services, but usually do not require (and may be negatively impacted by) intensive supervision.
4. Veterans identified as **high** risk / **low** need often require supervision and habilitation, but typically do not require substance use or mental health treatment.



**Instructor:**

You'll now take a brief quiz to on the topics related to responsivity covered in Module 5.

You'll have ten minutes to complete the quiz and then we will review the answers. After reviewing the answers, we'll take a ten minute break.



**Instructor Note:**

Ask participants to open their Participant Manual to pages 61.

Give participants ten minutes to complete the quiz.



**Answer Key:**

Take five minutes to review the correct answers with the group. See instructor answer key above.

## Break

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## Diagnostic Self-Assessment

Time: 15 minutes



### Instructor Note:

At this point, hand out the Diagnostic Self-Assessments. Give the group 15 minutes to fill them out independently and then collect them at the end. Save them in an envelope until the end of the course.



### Instructor:

Congratulations! You've made it to the end of the VICTOR curriculum. We will now take a few minutes to redo the diagnostic self-assessment that we completed at the beginning of the course. As a reminder, the self-assessment is divided into two sections, or subscales. The first is designed to assess knowledge of military and veteran culture, while the second measures your confidence in your own responsivity skills related to veteran issues. For both subscales, review each statement in the first column and circle the number that best describes your level of agreement based on the rating scale provided. Be candid in your responses as this self-assessment process is an opportunity to identify your own strengths and areas that you have grown. Take 15 minutes to complete the assessment, and then hand it in to me. Have a great day!